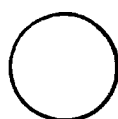


**GENDER DIFFERENCES IN PERCEPTIONS OF PAIN: TOWARDS A  
PHENOMENOLOGICAL APPROACH**

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**This is submitted for the Degree of Doctor of Philosophy in Sociology at the University  
of London.**



## ABSTRACT

This research explores the relationship between perceptions of pain and illness and the social characteristics of the individual, with a focus on the role of gender. It emphasizes the meaning and understanding of the phenomenon of pain, which as an area of research has been neglected by medical sociology. A survey of sociological, medical, psychological, anthropological and literary perspectives on pain reveals a consensus that pain is a 'subjective' phenomenon, and that there are therefore limitations in applying 'objective' measurements. Recent developments in the sociology of health and illness, particularly in the area of emotions, offer potential theoretical and methodological frameworks and these are explored. To try to broaden the definition of pain beyond the traditional biomedical approach a multi-method form of enquiry was adopted. A self-completion questionnaire examining health beliefs, and experiences of illness and pain during the life-cycle, was administered to a random sample of 107 men and women attending a GP practice in North West London. Significant gender differences were found with respect to the role of the emotions and social expectations of coping ability. These themes formed the basis of the second stage of fieldwork, in which a sub-sample of 21 men and women participated in a semi-structured in-depth interview, including the use of visual imagery. This explored definitions and experiences of pain. Responses were tape-recorded and transcribed. Analysis of both the transcripts and the material relating to the use of visual imagery revealed complex and abstract conceptualisations of pain, related to the social context of the individual. Experiences of pain were found to incorporate feelings and vulnerabilities, and existential and religious beliefs as well nociceptive or sensory components. The attribution to women of superior capacities in coping with pain were phenomenologically linked to female biological and reproductive functioning, but also seen to be underpinned by gendered socialization and role-expectations.

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## **CHAPTER 1**

### **THE SOCIOLOGY OF HEALTH AND ILLNESS: SOME CONCEPTUAL, THEORETICAL AND METHODOLOGICAL CONSIDERATIONS.**

**'If you would call a physician, that is thought good, for the disease you complain of is but unacquainted with your body, and therefore may put you in the way for a present cure, but overthroweth your health in some other kind; and so cure the disease and kill the patient.'** (Bacon [1561-1626])

#### **Introduction**

The background literature for this thesis draws on the disciplines of psychology, sociology, medicine, anthropology, and epidemiology, and forms the context within which the more specific objectives concerning the exploration of pain and gender are located. In this chapter, the background literature is surveyed, with a view to identifying the main relevant theoretical, conceptual and methodological issues relating to the study of health and illness. The next chapter examines the concept of gender and its utilisation as a variable in studies of health and illness. Theories of the perception, measurement and explanation of pain are considered in Chapter 3.

#### **Conceptualising health and illness: the biomedical model**

The development of a biologically deterministic model of health and illness is historically linked with the rise of the medical profession. But the 'medicalisation' of health and illness is a strand in the nature/nurture debate which has a long history, centred on the interaction between biological and cultural determinism.

The notion of 'disease' can be traced back to Hippocrates, with the postulation that a combination of signs and symptoms can be observed to occur together so frequently and so characteristically as to constitute a recognisable and typical clinical picture (Clare 1977). This 'disease' model was highly influenced by the philosophy of

Rene Descartes in the seventeenth century, which instituted the radical pronouncement of the independence of mind and body. Descartes saw the mind as activating the will of the human spirit through the subordinate physical matter of the body, a view in opposition to the predominant philosophical stance of orthodox Christianity on the inseparability of body and soul, which had until then retarded the development of medical science by forbidding dissection (see Hart 1985). As well as its revolutionary implications for anatomical study, the mind/body dualism of Descartes had a profound influence on the development of positivist science. Logical thought based on empirical observation was emphasized, laying the foundations of the mechanistic bio-medical approach which characterises Western medicine. Whilst the advancement of medical knowledge instigated by Cartesian dualism is acknowledged, it has also been argued that the Cartesian 'revolution' has limited the scope of medicine. Ryle (1949), for example, has emphasised the dangers and limitations of proposing two collateral but separate histories - those of the mind and the body; other dualisms emerging with the mind/body split are also important, such as mental/physical, public/ private, and outer/inner. Recently, salient epistemological enquiries around these dualisms have emerged from within the sociology of health and illness. Major advances have evolved through feminist analyses of medical science as a social product, and the development of qualitative methodological approaches, grounded in humanist philosophy.

In the nineteenth century a major paradigm shift in the conceptualisation of disease within the biomedical model occurred with the development of the doctrine of specific aetiology or 'germ theory'. Much influenced by the earlier work of Thomas Sydenham (1624-1689), known as 'the English Hippocrates', who emphasised the need to differentiate illnesses from each other, this doctrine was generated by the work of

Louis Pasteur (1822-95), and of Robert Koch (1843-1910), who demonstrated that disease has specific causes which can be identified and treated. The separate and specific aetiologies of infectious diseases such as scarlet fever, measles, gout, smallpox and malaria were thus identified. This emphasis on specific disease categories resulted in the body being considered analogous to a machine, whose individual parts could be examined and treated without the rest of the body being affected, serving to deflect attention away from the environment and the individual's relationship to it. This paradigm, which has dominated medicine ever since, gains much of its credibility from the association of scientific breakthroughs with dramatic declines in mortality rates.

A major critique of the biomedical model has been provided by McKeown (1979). Using a large-scale analysis of available epidemiological statistics of mortality decline in England and Wales, he argues that the contribution of medical intervention has been over-emphasised, and demonstrates how most of the decline in mortality from infectious disease occurred before effective immunisation became available, with the possible exception of smallpox and diphtheria. McKeown's thesis restates the main determinants of the public health as improvements in environmental health measures leading to better sanitation and a purer water supply, plus limitations in family size, and, most importantly, improved nutrition. Although the essence of the McKeown thesis is still regarded by many as 'the best explanation for the historical fall in mortality' (Farrow 1987), there are counter-arguments. For example Szreter (1988:5-6) argues that the rapid population growth associated with initial industrialisation in Britain was mainly due to a rise in fertility consequent on earlier marriages, rather than to falling mortality rates. He also criticizes McKeown's claim of 'a single movement of continuous and uninterrupted mortality decline' over the last three centuries, pointing out that the eighteenth century

fall in mortality was of a similar scale to the pre-industrial fluctuations of the sixteenth and seventeenth centuries.

The dominance of the biomedical model of health and illness resonates in practical, as well as conceptual implications. For example, critics of the National Health Service in the U.K. argue that it can be seen to consist of the following chief features:

1. An orientation towards cure, towards the manipulation of organic symptoms with the intention of effecting their disappearance.
2. Perception of disease as an autonomous and potentially manageable entity which threatens personal health in a temporary or episodic fashion.
3. A focus on the isolated individual as the site of the disease and the appropriate object of treatment.
4. A belief that the most appropriate place for treatment is a medical environment - the consulting room or the hospital - not the environment where symptoms arise. (See Hart 1985:11-12.)

Use of the biomedical model for research on health and illness has resulted in a focus on the production and analysis of statistics of mortality and morbidity. Medical, and to a large extent, social, research in the health field, has traditionally been dominated by positivism, and by an alignment with the medico-scientific method. The search for objective measures of the health status of a population has a long tradition in public health and demography, and the dominant perspective emphasizes statistics of mortality and morbidity as a major source of empirical data. Birth and death rates are used to infer the health of populations, but there are difficulties in using crude death rates. Age-specific or sex-specific rates may be calculated separately, and standardised mortality rates (SMRs) can be obtained when a summary measure for the total population is required. Infant mortality rates (IMRs) are often used to make international comparisons (see Social Trends 21:115), and are inferred to reflect broad social conditions, as well as

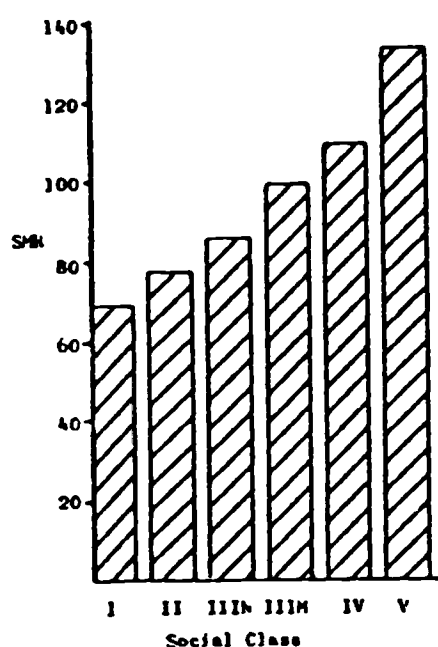
the availability of maternal and infant services. Similar comparisons are made with morbidity statistics, which form part of the background to health policy decision-making and epidemiological and clinical research on the causes of particular diseases.

### Health and the social structure

The problem of defining health is inextricably interwoven with the issue of measurement. Whereas the use of medical statistics has been of tremendous value, fuelling major debates such as that around inequalities in health, the terms of this and related debates have highlighted the location of health within the social structure. Figures 1.1. and 1.2. show a correlation between the lower social classes and higher health status for both men and women. Despite a long-term fall in all-cause death rates in Britain, this improvement has not been experienced equally.

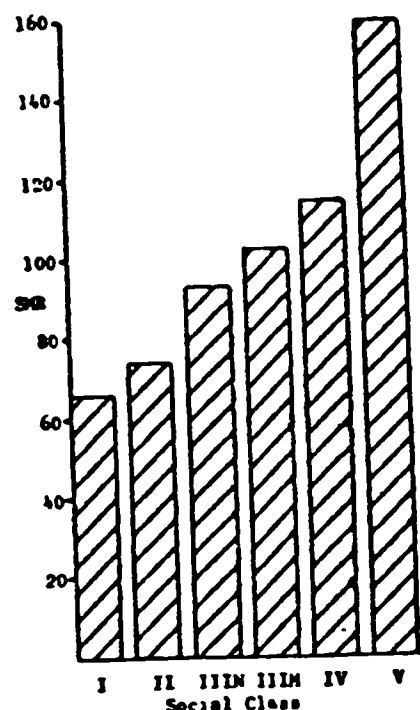
**FIGURE 1.1**

**Mortality of Women aged 20-59  
by Social Class in Great Britain,  
1979-83.**



**FIGURE 1.2**

**Mortality of Men of Working  
Ages by Social Class, Great Britain,  
1979-83.**



Source: OPCS

All the major killer diseases (and most of the less common ones) can be shown to affect the poor more than the rich. The less favoured occupational classes also show higher rates of chronic sickness, and their children have lower birthweight, shorter stature and other indicators of poorer health status (Whitehead 1987).

Four possible explanations of these social class differences in health risk have been elaborated. The **artefactual** explanation suggests that the method of measuring occupational class, by the Registrar General's social class classification, artificially inflates the size and importance of mortality and morbidity differentials (see Illsley 1986). However, the converse is argued by Marmot et al (1984), who claim that the classification leads to under-representation of these differentials. The second explanation, that of **health selection**, suggests that the differences are 'real' but caused by 'natural' health selection processes, so that people in poorer health tend to move down the social scale and concentrate in the lower social classes, while people in good health move up into the higher social classes, giving rise to a continuous and inevitable gap between the classes, despite overall improvements in general health (see Illsley 1986; Wadsworth 1986). The third **cultural/behavioural** explanation stresses differences in the way individuals in different social groups adopt behaviours and lifestyles. Health inequalities are said to emerge as lower social groups engage in 'higher-risk' behaviour, the most well-known example being cigarette-smoking. In 1983 the Royal College of Physicians estimated that at least 90% of deaths from lung cancer, chronic bronchitis, and obstructive lung disease, and 20% of deaths due to coronary heart disease were related to smoking (Social Trends 1987:120). Lastly, the **structural/materialist** interpretation emphasises the role of the external environment and the conditions under which people live and work, which in turn influence the health behaviours they adopt. Inequalities result because the lower classes



have poorer housing and poorer material circumstances generally, including fewer resources to access health services. As the Black Report notes, these explanations are not mutually exclusive, but the weight of the evidence is in favour of the structural/materialist interpretation.

The health inequalities discussion has been brought forward and elaborated by another report, The Health Divide (Whitehead 1987), commissioned by the Health Education Council. This confirms the persistence of social inequalities into the 1980s, and supports both the structural/materialist explanation and the cultural/behavioural one. Whitehead proposes (1987:62-63), in conjunction with others (Blaxter 1983; Blane 1985), that these two interpretations are inextricably interlinked, and recommends extending the analysis in several different directions, beginning with **age**. Data on occupational class mortality have now been extended to ages over 65, and still a substantial class gradient persists. A second important dimension is that of **self-perceived health**: the class differentiation of illness has been paralleled by class differences in self-perceived health and well-being, with lower occupational groups experiencing more chronic and incapacitating illness. Although it is taken for granted that sickness will happen to almost everyone sooner or later, it seems that lower occupational groups experience it **earlier**: this must be seen as a **major inequality**. Thirdly, measures of **housing and employment** status are importantly related to health risk. Owner-occupiers have lower rates of illness and death than private tenants, who in turn have lower rates than local authority housing tenants. The unemployed have poorer mental and physical health than people with jobs. A fourth dimension is **gender**. Women can expect to live longer than men and have lower mortality rates at every stage in life. However, women also record higher levels of morbidity than men, particularly from middle-age onwards. Fifthly, **regional differences**

in health in Britain are evident. In addition to the well-known North/South divide, it is now becoming apparent that great inequalities in health can exist between small areas in the same region. Areas suffering social and material deprivation have been found to have much poorer health profiles than neighbouring affluent areas. Furthermore, the gap between the health of the rich and the poor is greatest in the north. A sixth critical aspect of this picture is **ethnicity**. Here, the limited research available reveals repeatedly that:

'... black and other ethnic minority people (especially those whose skins are not white) have an overall worse health experience than the white population' (Baxter and Baxter 1988:642).

However, information on the health of ethnic minorities is limited to studies of adult immigrants born outside England and Wales, with hardly any information on the health of the second generation. This gives rise to a varied and incomplete picture.

### **Towards a social model of health**

Until the 1960s, medical sociology was dominated by functionalist perspectives originating in the work of Talcott Parsons. The Parsonian model was built on the assumption that society is a unitary and homogenous social structure within which participants generally accept and respond to a single value system. Parsons employed an ideal type model as an analytical construct, and his interest in the medical process was largely as an illustration of his general theory of social systems (see Morgan et al 1985). The functionalist perspective was particularly influential in the development of a literature on the sick role, the therapeutic role, and labelling theory, and in the analysis of the organisation of hospitals (Parsons 1951).

A good deal of work has delineated social aspects of health and illness using these concepts. A particular body of knowledge has developed around illness behaviour, often

blending sociology, psychology and epidemiology. For instance, studies show that only between a quarter to a third of individuals with symptoms they define as illness will actually consult a doctor (Tuckett 1976; Mechanic 1976) resulting in the 'illness iceberg' phenomenon, which has also been shown to be gender-patterned (Verbrugge 1985). The division between the perceptual aspects of illness (as measured by reported symptomatology) and the behavioural aspects of illness behaviour (measured by physician visits) can give rise to working models of health and illness (see Fig 1:3, for example):

**FIGURE 1.3      ILLNESS BEHAVIOUR MODEL**

<b>DISEASE</b>	<b>ILLNESS</b>	<b>ILLNESS BEHAVIOUR</b>
disease ----->	PERCEPTION ---> AND EVALUATION OF BODILY	'ill' -----> action
no disease --->	STATE ---->	'not ill' ----> no action

Disease = medical conception of pathological abnormality indicated by a set of signs and symptoms.

Illness = primarily a person's subjective experience of ill-health, indicated by person's feelings of pain, discomfort etc. Possible to have disease without feeling ill and to feel ill without having disease. Subjective interpretation of certain bodily feelings.

Illness Behaviour = action or non-action, that people take once they have interpreted bodily states as being signs or symptoms of illness.

Source: Sharp 1981:18.

However, functionalism itself, and especially the notion of the sick role being deviant, provides little challenge to the limiting assumptions of biological determinism built into the medical model. The transition, over the last twenty years, from so-called 'medical' sociology to the sociology of health and illness (see Stacey 1988) has resulted in a movement away from the traditional emphasis on problems defined by

epidemiologists and policy makers, and researched by traditional empirical and quantitative methods. A plethora of challenges to the biomedical conceptualisation of health and the organisation of medical practice have resulted.

The reconceptualisation of the biomedical model as a social one is methodological, as well as theoretical. The parallel critique of positivist empiricist methodologies has formed a major debate within the social sciences. For example, Cornwell's work stresses the need to theorize on the basis of lay accounts of health and illness (Cornwell 1984). She argues that the process of medicalisation implies a relationship between two groups, namely 'consumers' or lay people with 'commonsense' health beliefs, on the one hand, and 'experts' or health professionals, on the other. Inevitably, this results in an imbalance of power, which is rationalised as the derivation of medical scientific and technical legitimations from analytic and scientific knowledge. Such legitimations supersede traditional or 'normative' ones, involving questions of human values associated with religious, metaphysical or moral systems of belief. The assumption of neutrality is questionable, although ideological inferences render actual power relations inaccessible to analysis and, indeed, to consciousness.

Similar tenets apply to mental illness. Using this example, Ingleby (1981) questions the assumption that knowledge is merely an accumulation of findings, which, if sufficient in quantity, constitute a body of theory. Such underlying empiricist suppositions are naive and incapable of explaining the social construction of mental illness. There is a need, instead, to examine the principles giving rise to the acquisition and interpretation of 'findings' - a process ultimately as philosophical as scientific. An alternative interpretative framework ascribes to humans the capacity for meaningful behaviour or 'praxis' - a process which cannot be objectively explained or categorised.

A framework of this nature would include subjective measures of health, as advocated by Blaxter (1985). She points out that health as defined by an administrator, social surveyor or medical professional is not necessarily compatible with the experience of those being surveyed. The 'surveyed' often have a more complex and contradictory concept of health than these methods of data collection can reveal. For example, more than half the respondents to the General Household Survey (OPCS 1984) reveal 'chronic health problems', and yet the majority of people also assess their own health as 'good' or 'better'. In this way 'normal' illness can be included in 'good' health.

Employing a more holistic approach to the whole person, rather than concentrating on the specific disease or illness, involves a shift towards a social model of health. This also places the individual within the wider social structure. To include environmental and social factors as major determinants of health clearly has important implications both for theory and practice, leading, for example, to an emphasis on strategies for the prevention of disease, rather than concentrating interests and resources entirely in the field of curative medicine.

The differentiation between social and biological models can be illustrated in a number of ways. We find, for example, in a traditional medical textbook prepared for nurses (Bloom 1979), and under the heading of aetiology, a rather narrow conception of the causes of disease as follows:

"The term aetiology is used to denote causation of disease. There are thousands of possible causes and the following classification gives only the main ones:

**1. LIVING ORGANISMS OR MICROBES**

- a) Bacteria
- b) Viruses
- c) Fungi
- d) Parasites

**2. PHYSICAL AND CHEMICAL AGENTS**

- a) Injury (trauma)
- b) Excesses of heat or cold
- c) Electricity, X-rays and radioactive substances
- d) Toxic drugs
- e) Poisonous gases
- f) Cigarette smoking

**3. DEFICIENCY AND HORMONAL DISEASES**

Lack or disturbance of :

- a) Vitamins
- b) Hormones
- c) Diet

**4. HEREDITY****5. AUTOIMMUNE DISEASES****6. UNKNOWN (including causes of tumours)'**

(Bloom:1979:8-9).

In contrast, the following extract from A Barefoot Doctor's Manual, prepared by The Revolutionary Health Committee of Hunan Province (1978), demonstrates how, in Chinese medicine, emotional and external factors are seen as intrinsic to disease:

**'SECTION 2. HOW TO ANALYZE CAUSES OF DISEASE**

To find the cause of disease, on the basis of the patient's signs and symptoms and the physical examination results, is an important step in the diagnosis of the disease. After physicians have gained a certain recognition of disease by the examination techniques just described, they must, in order to understand and make a correct diagnosis, make an overall study of the patient's attitudes, mental activity and illness to correctly differentiate between the etiology and the present course of the disease. The human

body is an integral mechanism in which inconsistencies contradict each other. It also has a very close relationship with society and its natural environment. The onset and development of disease frequently are related to the body's makeup, its resistance and the virulence and number of pathogens present, in a complex relationship. The following sections list some causes of disease in the human body; the important ones refer to mental activity and the physical makeup of the human being:

## **BODY FACTORS**

### **1. Nervous and Emotional Make-Up**

Mental and emotional activity among different individuals vary under the different influences of society and the natural environment. Examples are joy, excitement, happiness, anger, fright and sorrow. Under most conditions, emotional activity will not cause disease, but under certain conditions it can damage normal body function and cause or hasten its development, e.g. certain neuroses or functional digestive disturbances. However, we must feel the dynamic effect of the proletarian world view and its revolutionary optimism on preventing or overwhelming disease. For example, some of our comrades who have incurred serious burns, because they can hold on to a fearless revolutionary determination to fight against disease, ultimately overcome it. This fully explains the dynamic the patient's subjective outlook can have on overcoming a serious illness.

### **2. Body Make-Up or Physical Conditions**

This includes the body build, body reactions and differences such as age, sex, resistance to disease, which are closely related to the incurrence and development of disease. After 1950, the large working masses were given regular training so their bodies may become healthy and strong, and less susceptible to disease. Furthermore, the aged or the young, because of a weak body makeup, may, because of weak resistance, be easily affected by disease-causing factors to become ill. The human body's reactions to external environmental and internal body factors may vary because of regional, age, sex and sensitivity differences. For example, children can easily be affected by infantile paralysis, while older adults are more susceptible to cancer. Some people are allergic to pollen, shrimp and crab, and develop wheezing or urticaria. Certain other ailments are commonly seen in men, and others more commonly seen in females. These are all closely related to the human body's reaction.

## **EXTERNAL FACTORS**

These include various social and natural environmental factors. Sometimes etiologic factors are quite complex.

### **SOCIAL FACTORS**

Differences in the social system often have a great effect on the incidence and

elimination of certain diseases. China has early eliminated cholera, smallpox, venereal disease, plague, etc. With respect to certain diseases with more serious consequences such as malaria and schistosomiasis, better prevention and treatment measures have greatly reduced the disease incidence. Therefore, when causes of disease are analysed, great emphasis must be given to the social system.

### **PHYSICAL FACTORS**

e.g. Radiation, mechanical injuries, war injuries, high altitude, high temperature, outer space activity etc.

### **CHEMICAL FACTORS**

e.g. Strong acids and alkalis, pharmaceuticals, cyanide products, organic phosphorous in agricultural insecticides and snake venom.

### **BIOLOGICAL FACTORS**

e.g. Pathogenic viruses, bacteria, fungi, spirochetes, protozoa, tapeworms etc. Biological pathogens attacking the human body are quite selective in their site of attack.

### **CLIMACTIC FACTORS**

Under normal conditions, natural climatic factors, such as wind, cold, heat, humidity, aridity etc. do not cause disease but if the climate changes suddenly and the body's resistance is lowered and cannot adapt immediately, the above elements are linked to certain symptoms in traditional Chinese medicine .

### **OTHER FACTORS**

e.g. unhygienic eating habits that lack discipline and control, can also be indirect pathological factors'

(Revolutionary Health Committee of Hunan Province 1978:25-26).

This extract demonstrates an intrinsically holistic approach to illness, in contrast to the more mechanistic, dualist biomedical model which is unable systematically to take on board the aetiological role of social and/or emotional factors.

### **The radical critique**

Major challenges to the medical model, and to a limited form of the social model, have been posed by social scientists and others. Interest in how far physical or psychiatric



disorder may be a result of living in a particular form of economic and political organisation or domestic environment can be traced back to Marx's and Engels' concern with the social relations of capitalism, and with the links between these and individual health and well-being. Whilst recognising the potential in terms of progress and civilisation of the (then embryonic) new economic system, Marx predicted the detriment of health and well-being which the concept of **alienation**, the result of inevitable class exploitation, would produce:

'Within the capitalist system all methods for raising the social productiveness of labour are brought about at the cost of the individual labourer; all means for the development transform themselves into means of domination over, and exploitation of, the producers; they mutilate the labourer into a fragment of a man, degrade him to the level of an appendage to a machine, destroy every remnant of charm in his work, and turn it into hated toil; they estrange him from the intellectual potentialities of the labour process in the same proportion as science is incorporated in it as an independent power; they distort the conditions under which he works, subject him during the labour process to a despotism the more hateful for its meanness, they drag his wife and child beneath the wheels of the juggernaut of capital' (Marx 1906-1909 1:708).

Despite fundamental differences in the two conceptions of society, similar concerns can be found in the works of Durkheim. For example, in Suicide (1897), the concept of **anomie** was used to identify the social causes of suicide by relating their rates in different social groups to social characteristics of those groups.

More recently, the sociological study of professions has led to the observation that the acceptance of a multi-causal model of health and illness by the medical profession has resulted in an increasing medical expansion into numerous areas of life which were previously outside medicine's sphere of influence (Zola 1977; Strong 1979). Medicine's claim to expertise is bound up with its rise to professional status. During the twentieth century the medical profession has increased its role, prestige and power, by extending into areas such as psychiatry and obstetrics on the basis of claims to 'scientific' expertise.

Thus medicine itself is increasingly becoming an institution of social control. Fredson, in a well-known statement, (1970:212) argues that:

'... the medical profession has first claim to jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively.'

A more extreme critique comes from Illich (1976) within the ethos of the de-schooling movement. Illich claims that the medical profession has not only misled the public into believing it has a unique, viable and irreplaceable body of knowledge and skills, but has also created a dependence on doctors and medicine which has denigrated people's ability to engage in self-care - a 'structurally health-denying effect'. As a result, medical intervention can be regarded as a potential threat to health. Illich's critique demonstrates a reaction to the increasing dependence on science and technology at the expense of spontaneous human capacities to control and shape individual destiny.

Feminist analyses have formed a central contribution in the critique of medicine as a form of social control. Research into childbirth and reproduction (see Oakley 1976,1980; Roberts 1981) has questioned the benefits allegedly resulting from the take-over by the largely male discipline of obstetrics, and has suggested instead that there may be a reinforcement of women's secondary social status by manipulation of their biology. The attitudes and practices of the medical profession have been shown to reflect the dominant interests of men, with women being measured against the male standard of 'normality', and the central determining characteristic of women being seen as their 'natural role to reproduce' (Barrett and Roberts 1978; Garrett 1984; Martin 1987). There has also been a significant contribution by feminist sociologists to methodological issues, resulting in innovative uses of the 'sociological imagination' in the past decade or two (Oakley 1980; Finch 1987; Smith 1987 and see Chapter 2 for a fuller discussion of this).

The medicalisation thesis is also central to the critique of social constructionism. In his discussion of illness, Sedgwick (1973) has argued that the notion of disease is human and is applied on the basis of social and personal values which can, and do, change. He cites examples such as hookworms being a normal part of health in certain areas of North Africa, and emphasises that any diagnosis of pathology embodies a degree of relativity. He also re-evokes the nature/nurture argument by stressing the inevitability of human decay, giving examples such as a fractured femur in a septuagenarian being as natural as '...the snapping of an autumn leaf from its twig', and infection by cholera as carrying with it '...no more the stamp of illness than the souring of milk by other forms of bacteria' (Sedgwick 1973:45).

Taking issue with these analogies, Clare (1977) has claimed they are deceptive, as they do not compare like with like. However, by identifying psychiatry within the biomedical model, Clare effectively concedes the lack of neat objectifiable definitions attachable to concepts of health and disease:

'If the contemporary critical assault on the medical model in psychiatry can claim any achievement, it is perhaps the somewhat ironic one of having forced a consideration, not so much of psychiatry's claim to be a medical discipline, as of medicine's claim to be a social science. Avoiding the dualism inherent the dichotomous formulation of organic versus functional leads not merely to an acknowledgement of the role of physicochemical alterations in psychiatric states but of psychosocial factors in medical conditions' (Clare 1977:33).

There are parallels here with Marxist analyses of health, in which the theme of the relationship between the needs of the economy and health is developed by viewing medical knowledge as largely determined by the bourgeois ideology of capitalism. The capitalist mode of production can be seen as damaging to health, firstly by its propensity to encourage consumption of hazardous goods (e.g. cigarettes, processed food, cars) and, secondly, by the mobility demanded by the capitalist labour market which erodes social

relationships based on kinship, neighbourhood and community (Hart 1985). Additionally, there is an 'exportation' of ill health to underdeveloped countries by various means such as the hazards of industrial processes and the dominance of western scientific medicine, which detracts attention from the basic social and environmental aspects of health (Doyal and Pennell 1979). In the work of Navarro (1979), the interventionist approach to health and the biomedical-functionalist model are seen as linked, in the sense that the industrial bourgeoisie is likely to support this approach because any attempt to eliminate or reduce social factors causing disease could lead to increases the cost of production. Criticisms of Navarro's thesis, on the other hand, point to its economic reductionism, which overlooks the existence of other sources of power in society.

Another contemporary influence on sociological theory is the work of Foucault, particularly his analysis of the history of medical theories in France. Foucault demonstrates how changing ideologies of disease can be seen as a product of differing perceptions of the body:

'Disease is no longer a bundle of characters dissociated here and there over the surface of a body and linked together by statistically observable concomitances and successions; it is a set of forms and deformations, figures and accidents, and of displaced, destroyed or modified elements bound together in sequence according to a geography which can be followed step by step. It is no longer a pathological species inserting itself into the body whenever possible; it is the body itself which becomes ill' (Foucault 1973:136).

For Foucault this 'political anatomy' is based on mechanisms of power rather than progressive enlightenment or random effect. These he terms the 'clinical gaze'. Turner (1989) suggests that, although the relevance of Foucault's work has been recognised for its potential to develop medical sociology, especially with regard to the body, the links need to be made systematic:

**'The Foucaultian "problematization" of the body as an effect of power and knowledge opens up exciting lines of research... a focus on the sociology of the body inside medical sociology would suggest new, or at least innovative, areas of inquiry, for example, into the complex interdependencies between self-image, personal identity, social interaction and body-image; it would also suggest alternatives to behavioural or informational models of pain' (Turner 1989:13).**

Factors such as the rise in popularity of 'alternative' medicine have encouraged holistic models. There is, for example, now a considerable literature on the relationship between stress and illness (for a recent review, see Pitts and Phillips 1990:45). One outcome has been the development of a hybrid science of 'psychoneuroimmunology' which demonstrates mechanisms by which psychological stress may, at least partly, cause physical illness of various kinds. For example, studies have shown higher cancer mortality rates for bereaved spouses (Fox 1981; Glaser and Glaser 1986). Similarly, 'life events' research of the type instigated by Brown and Harris (1978), to look at depression in mothers of dependent children in Camberwell, is given empirical justification with an increasing body of 'findings' supporting psychosomatic links. For instance, poorer immune function, including measures of increased lymphocytic responsiveness, are shown by separated and divorced women in a matched controlled sample (Evans et al 1984). Other studies show increased susceptibility to upper respiratory infections and other physical symptoms in subjects who had experienced recent pronounced change in life-event scales (Evans and Edgerton 1989; Bruce and Neale 1988).

### **Integrating social and biomedical models**

A great challenge lies in a rapprochement between the two models of health and illness. Whilst bio-medical research will continue to be vital, it is also important to advance understanding of the social and socio-economic factors which play a part in the promotion of health and the causation of disease, and of the relationship between these

and the broader social structure. Instead of remaining embedded in debates between biological and cultural determinism, the way forward is suggested by Rose et al(1984:10) as 'an integrated understanding of the relationship between the biological and the social'. Although definitions of health and illness vary between medical and social models, there are no universally valid, comprehensive and agreed definitions; and there is great variability between cultures, historical periods, individuals (and even the same individual over time). Health is an important variable in social processes. Whether relating to individuals or social groups, it can interact with other characteristics such as gender, race or class to exert a major influence on life chance or experience. It becomes impossible to ignore the political dimensions of the ways in which health and illness, and the relationship between the individuals manifesting these and the wider social structure, are conceptualised. Once health is conceptualised politically, a broad division is evident between biomedical and social models of health. The 'social model' of health extends beyond the freedom from disease and pain, to encompass positive notions of energy, well-being and interaction with the community, as in the somewhat Utopian definition adopted by the World Health Organisation (1983:12 ): '... a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity'. This definition has been criticised for being impossible to operationalise, as the concepts may be too vague and the value-judgements of the definer result in

'... measurement [becoming] too orientated towards social perceptions and culturally-rooted patterns of behaviour so that health in this context has meaning only in a defined set of values and cultural norms, making comparisons difficult' (Hansluwka 1985:1220).

The move towards a social model of health poses a new set of methodological questions, as the concepts involved become broader and increasingly abstract. The concept of 'well-being', for instance, is open to a multitude of culturally specific

interpretations, and does not fit into the traditional 'split' between physical and mental conditions postulated by the biomedical model. The same is true of the study of perceptions of pain - the central focus of this thesis - which lies at the intersection of medicine and social science. Traditionally, social science research in this area is dominated by the field of psychology, particularly psychophysics, but the thesis will argue the place for a sociological input. It will also contend that limits on our acquisition of knowledge result from 'territorial' claims by disciplines, and a general mistrust of eclecticism. So far as the contribution of psychology is concerned, Harre and Secord (1972:2) point out that, although 'naive behaviourism' is subject to criticism, there remains a generalised adherence to positivist methodology, despite the fact that empirical studies only make sense if people are conceived of in the mechanical tradition as 'passive entities whose behaviour is the product of impressed forces'. They advocate that an **adequate** social psychology must provide a general theory of social action and genesis, and must be a co-operative enterprise between philosophy, psychology and sociology so that each area can compensate for inadequacies of the other:

'Psychologists are concerned with too narrow a conception of social action, severely handicapped by social naivete. Philosophers have not lacked conceptual sophistication but too often have been ignorant of social and psychological facts. Sociologists, despite a great breadth of conception, have been unable to develop theories of individual social action, and have suffered from conceptual naivete' (Harre and Secord 1972:2).

The potential for psychology to 'transcend' itself, by attempting to understand the social context of its various approaches and traditions is echoed by Buss (1975) in his plea for the development of a sociology of psychological knowledge. The purpose of this exercise would be to:

'... begin understanding the role of politics, ideologies, values, economic systems, and in general, society and its underlying strategies and dynamics - in the birth, development and death of some of the classical psychological

theories, perspectives, paradigms, models or approaches that have and continue to exert considerable influence' (Buss 1975:991).

Acknowledging the enormity of this task, Buss identifies key issues in the form of antagonistic paradigms such as nature/nurture, behaviourism/humanism, and mechanistic/holistic. However, he warns against trying to resolve their differences by a logical progression of refutation, as the differences stem from ideological assumptions and metaphysical values. Buss accentuates the value of engaging in these debates in terms of both intellectual and personal development which result in greater exposure to a variety of intellectual traditions, value systems, and perceptual frames of reference, resulting in an enriched development of the individual.

## **Conclusion**

This chapter has outlined some of the major theoretical and methodological issues relevant to a study of pain perceptions located within the discipline of the sociology of health and illness. Although social models provide challenges to the dominant biomedical paradigms, there are theoretical and methodological dilemmas, which are often rooted in fundamental philosophical underpinnings. In his plea for the development of sociology of the body, Turner notes that:

'Sociological Cartesianism has blocked the development of existentialist notions of embodiment. The action categories of sociology have tended to be hyper-rationalistic, precluding any fundamental understanding, for example of feelings and emotions' (Turner 1989:12).

By its very nature, pain lies at the intersection of biology and culture. In order to assess the potential contribution of a sociological perspective, the emotional, psychological, social, existential and spiritual components of its perception must be taken into account. To provide some access to the multitude of concerns that are generated in this process, the next chapter examines the relationship between gender, on the one hand, and the



ways in which human emotions are explored and represented in social science, on the other.

## **CHAPTER 2**

### **GENDER DIFFERENCES IN HEALTH AND ILLNESS..**

'When we do not know whether men or women view the same things as symptoms of illness, when we do not know to what extent physicians diagnose the same symptoms differently in men and women, when we do not know about the differential effects on men and women of the hospital experience, how can we theorise about sex differences in illness?' (Clarke 1983:77).

This chapter reviews the evidence for differences between men and women in their experiences of health and illness, and discusses some of the interpretations of these differences that have been advanced over the years.

#### **Gender differences in mortality and morbidity**

Large-scale health surveys carried out in Western industrialised countries reveal the conundrum that 'women get sick and men die'. In other words, women have a higher life expectancy in terms of mortality, but they also have higher rates of acute and chronic conditions.

In a germinal review entitled 'Sex Differentials in Health and Mortality', Verbrugge and Wingard (1987) show how U.S. males have an 80% higher age-adjusted death rate than females, so that, in 1980, the life expectancy for males was 70.0 years, compared to 77.5 years for females. These ratios have been shown to have a similar pattern throughout 1941-1951 and 1959-1961 (Sauer 1974) and during 1968-1972 (Wingard 1984). There are variations in geographic area and by ethnicity: mortality rates are higher in the south-east of the U.S.A, and differences in mortality rates between the sexes in the U.S. are greater for white than black ethnic groups, presumably due to the poorer socio-economic circumstances of the latter. International comparisons with other industrially developed countries yield similar patterns in mortality rates between the sexes, ranging from a difference of 8.5 years in Finland to 3.5 years in Greece (Wingard

1984). A study of sex differences in illness in Hong Kong by Sharp (1985) shows similar patterns in illness and mortality as in the West. The leading causes of death are degenerative diseases, particularly cardiovascular and cancer; and males have a higher mortality rate than females in all age groups above 5 years. However in underdeveloped countries the picture is more variable; for example in India, Waldron (1983) shows that males have a three year advantage over females, reflecting factors such as inadequate diet and health care, and especially the associated risks and rigours of pregnancy and childbirth under these conditions. For these reasons, sex differences in life expectancy are sometimes used as an index of economic development. In developed countries, there is increasing evidence that the mortality gap has begun to narrow since 1970, which must have implications for the relationship between sex roles and mortality:

'The general consensus of researchers is that the steady increase in the sex differential between 1900 and 1970 can be attributed to decreasing mortality rates for diseases affecting only women (i.e. maternal mortality and cancer of the uterus) and increasing mortality rates for diseases affecting principally men (i.e. cancer of the lung and cardiovascular disease). After 1970 the secular trend changed, in that the widening of the sex differential in mortality slowed down until the ratio stabilised at 1.80 between 1977 and 1980. This recent stabilization is because sex differentials for specific leading causes of death have either decreased, remained stable, or increased at a slower pace' (Verbrugge and Wingard 1987:108-109).

In addition to the mortality differential, major studies using survey data in the U.S., such as those of Gove and Hughes (1979) and Nathanson (1980) have repeatedly shown that, as well as having higher rates of both acute and chronic conditions, women have more restricted activity per condition and record more use of the medical services and higher rates of prescriptions. These higher rates for women obtain even when reproduction and its disorders are excluded. The patterns in the U.K. show very similar features. Table 2.1 shows chronic and acute sickness data by sex and age for Great Britain in 1990. There is an excess of female over male morbidity in all categories over

the age of 16, and the excess increases with age.

**TABLE 2.1: CHRONIC AND ACUTE SICKNESS BY SEX AND AGE, GREAT BRITAIN, 1990.**

		AGE						
AGE GROUP		0-4	5-15	16-44	45-64	65-74	75+	TOTAL
		Percentage who reported						
A) Long-standing illness:								
	Males	14	20	25	46	58	66	33
	Females	12	17	25	47	61	70	35
	All persons	13	19	25	46	60	69	34
B) Limiting long-standing illness:								
	Males	5	9	13	29	38	47	19
	Females	3	7	14	30	42	53	22
	All persons	11	8	14	29	40	51	21
C) Restricted Activity:								
	Males	13	11	11	14	14	15	12
	Females	10	13	13	17	16	22	15
	All persons	11	12	12	16	15	20	14
Bases = 100% Males		831	1719	4614	2494	999	539	11196
	Females	852	1607	4859	2651	1195	1004	12168
	All persons	1683	3326	9473	5145	2194	1543	23364

Source: General Household Survey O.P.C.S. monitor 1991 SS 91/1

In addition to these physical health differences, there are gender differences in the field of mental health. Women have repeatedly been shown to have higher rates of psychiatric admissions to hospitals, and of G.P. consultations labelled as psychiatric (see Gove 1978; Smith 1975; Busfield 1983). Cochrane (1983:41) demonstrates that overrepresentation occurs selectively, and the female excess is largely due to the categories of depressive psychoses, psychoneuroses and other categories which fall under

the broad heading of depression.

Over the last fifteen years, there has been a proliferation of interest within social science research in gender differences in morbidity and mortality. A number of hypotheses have been advanced to account for them. These can be grouped into the following categories:

1. **Biological aspects of illness risks**  
Those arising directly from different reproductive functions and those linked to aspects of different female/male genetic constitutions.
2. **Acquired risks of illness from gender roles**  
Associated stresses of life styles, sex-typed occupations, exposure to hazards at work or in home i.e. women have more illness than men because their assigned social roles are more stressful.
3. **Different health and illness behaviours and concepts associated with masculinity and femininity**  
Women report more illness than men because it is culturally more acceptable for them to be ill; differential childhood socialisation leads males and females to differ in their perception, evaluation and response to symptoms.
4. **Different diagnoses and treatments**  
The way in which professional health practitioners view gender roles, gender differentiated access to health services.

[see Busfield 1983; Verbrugge 1985; Stacey 1988]

### **Talking about gender**

In order to examine these hypotheses in greater detail, it is necessary to firstly define what is meant by the term 'gender' as distinct from 'sex'. Oakley (1972) makes a clear distinction: whereas sex refers to the most basic physiological differences between men and women - genital differences and reproductive capacities - gender refers to culturally specific patterns of behaviour which may be attached to the sexes. 'Sexual' differences refer to genetically determined differences between females and males. Gender, however, implies a culturally determined distinction between feminine and masculine, which is

extremely variable. Money (1965) identified six determining factors in the distinction between females and males, as follows: (1) chromosomes; (2) hormone balance; (3) internal genitalia; (4) external genitalia; (5) gonads; (6) sex assignment and socialization. If all six features coincide, this leads to 'a unitary gender identity' in the person concerned. The lack of a necessary relationship between biological factors and social roles is demonstrated by studies of transsexuality, androgyny and role-reversal. Most societies operate with perceived 'norms' of masculine and feminine attributes and roles, so that although the impact of biological differences may be limited in itself, it can be compounded by culturally prescribed gender effects.

Rose et al (1984) emphasise that 'sex' and 'gender' should never be seen as dichotomous in the way that medicine often differentiates between organism and environment. They argue against biological determinism by emphasising the continuous interaction between the two. This does not imply that the biological domain is to be rejected; it may provide shape and set limits to human experience, but is fundamentally inadequate for revealing social meaning and significance.

Biological categories are culturally defined, and these cultural definitions change over time. Thus women as a biological category have been under investigation within science since the latter half of the nineteenth century, in part as a response to the changes consequent on the growth of industrial capitalism. According to Tyler (1965) the development towards the end of the last century, of 'sex difference research', particularly in social psychology, was primarily... motivated by the desire to demonstrate that females are inherently inferior to males' (1965:240). The early twentieth century gave rise to increasing challenges by the women's emancipation movement and general political moves towards enfranchisement. Klein (1946) goes as far as to point out that:

'There is a peculiar affinity between the fate of women and the origins of social science, and it is no mere coincidence that the emancipation of women should be started at the same time as the birth of sociology' (Klein 1946:17).

This sentiment is echoed by Tyler, who maintains that from the turn of the century onwards, findings within sex difference research have given much weight to feminist arguments that social differences between the sexes are not biologically determined. This is a claim, however, that Connell (1979) refutes, referring to the continuing nature/nurture debate and the biological claims and assumptions underlying research on sex and gender differences. The core of this research is work which examines differences in cognitive skills and personality traits, and which results in a blurring of the disciplines of sociology and psychology, and the so-called 'sex-role-identity paradigm'. In considering whether any 'theory of gender' can be said to emerge from this field of research, Connell maintains that, whereas there may be problems in identifying a tightly-knit and logical body of thought, there is certainly a network of insights and connections, with two identifiable main strands. The first can be loosely termed 'sex role theories', originating from the work of Talcott Parsons (1953) and the school of personality and culture theorists to which Margaret Mead belonged. Both of these emphasised attitudes and social expectations. Mead's famous Samoan study (1935) challenged the concept of 'natural' differences between the sexes; namely the assumption that because of their respective biological make-ups, women will engage in child-rearing and domestic tasks, and that men will manifest an aggressive sexuality and a presence in the public domain. Mead's research has come under criticism in recent years by Freeman (1983), who claims that there are major conceptual and methodological deficiencies and that the limitations of her approach were due to:

'... the doctrine of cultural determinism [which] was formulated in the second decade of the twentieth century in deliberate reaction to the equally unscientific doctrine of extreme biological determinism' (Freeman 1983:302)

Parsons had used the term 'sex role' as early as 1942. He described men's roles as being **instrumental** and women's roles as **expressive**, and stressed the breadwinner/homemaker differentiation without any assumption of superiority/inferiority. Instead, the tension is seen as a social problem, and 'The feminine role is a conspicuous focus of the strains inherent in our social structure' (Parsons 1942:95). The unaddressed problems within social policy resulting from such strains were discussed by Richard Titmuss in 1958, using statistical evidence to demonstrate historical contrasts in women's experiences. Titmuss pointed out that:

'... it would seem that the typical working mother of the 1890s married in her teens or early twenties and, experiencing ten pregnancies, spent about fifteen years in a state of pregnancy and in nursing a child for the first year of its life. She was tied, for this period of time, to the wheel of childbearing. Today, for the typical mother, the time spent would be about four years' (Titmuss 1958:91).

A second strand in theories of gender focuses on the power relations between the categories 'male' and 'female'. The concepts of patriarchy and sexual politics are crucial, as developed in the works of such writers as de Beauvoir (1959) and Mitchell (1975).

Patriarchy has been defined as:

'The institutional all-encompassing power that men have as a group over women, the systematic exclusion of women from power in society, and the systematic devaluation of all roles and traits society has assigned to women' (Popkin 1979:199).

Stacey (1988:8) points out that the term 'patriarchy' can be confusing, firstly because it has a specific technical meaning within anthropology, and secondly because usage often fails to distinguish between male authority in the family and in society generally. For clarification, she recommends reserving the use of 'patriarchy' for kinship relations and



using 'male-dominated gender order' in the wider societal context. 'Sexism', a key related concept, exists where there is an inherent and structural discrimination in favour of one sex over the other. In talking and theorizing about gender, it is important to consider other forms of social categorization. Thus, for example, black feminist writers have criticised the implicit assumption that all women have the same struggles, especially around issues of reproduction and the family. Whereas traditional feminist critiques (see Barrett and McIntosh 1975) view the family as the main site of oppression, black feminists such as Bhavnani and Coulson (1986) point out that for many black women the family can be a refuge from the hostile racist world outside. Similarly, black motherhood is often perceived negatively and pathologised (see Anthias & Yuval-Davis 1983; Bryan et al 1985; Phoenix 1990). Marginalisation also occurs for lesbian and disabled women. In other words, an effective analysis of gender must be cross-cut with other variables such as race and class as 'women' do not constitute a homogenous group.

A fundamental theoretical point is made by Stacey (1981), who argues that any analysis of gender requires a distinction between the public and private domains. The public domain implies the essentially political arena of state institutions which exercise power and control, while the private domain is the domestic sphere. Whilst recognising that the relationship between the two is not mutually exclusive, Stacey argues that sociological theory has been limited in its analysis of the division of labour. This is linked with the historical dominance of sociological theory by men who developed it exclusively to explain the public domain. The central problem is:

**"The Problem of the Two Adams... one that it all began with Adam Smith and the other that it all began with Adam and Eve. The first has to do with the production and the social control of the workers and the second with reproduction and social control of women. The problem is that the two accounts, both men's accounts, have never been reconciled. Indeed it is only as a result of the urgent insistence of feminists that the problematic**

nature of the social order related to reproduction has been recognised' (Stacey 1981:172).

The public/private theme in the division of labour has been linked continuously to the instrumental/expressive roles (see Oakley 1972; Cancian 1987), and the concepts of **Gemeinschaft** and **Gesellschaft** outlined by Tonnies (1963) in his account of the decline of the community. In short, gender roles are assigned 'specialisms' - work for men, love and the family for women.

### **Analyzing gender**

These gender divisions can be shown to permeate research on health and illness, both theoretically and methodologically. In a critique of the 'invisibility' of women in the production of government statistics, Oakley and Oakley (1981) argue that sexism permeates the production of statistics on a number of different levels, including:

1. The areas chosen for analysis.
2. The concepts employed to organise and present the statistics.
3. The collection of data.
4. The processing of statistics.
5. The presentation of the statistics.

The use of gender as a key variable can operate on different levels. Key variables in social research are defined by Burgess (1986) as:

'the representation of a social characteristic or social factor in empirical research. Variables are constructed by defining a concept and developing an indicator or indicators' (Burgess 1986:14).

In a major review of research on gender and health, Verbrugge (1985) sets out a 'Social Science Agenda' in which she lays emphasis on the need to study how men and women perceive, evaluate and care for symptoms, and provides guidelines as to how to proceed. These can be summarised as follows:

1. In order to 'explain' gender differences, it is necessary to identify factors which are important causes of illness, injury or health actions and which differ between men and women.
2. Tests of psychosocial factors should control, wherever possible, for acquired risk factors identified in epidemiological and social research.
3. The best tests will come through study of specific symptoms and diseases.
4. Differentiation between 'major' and 'minor' health problems is necessary.
5. Reproductive events and sex-specific conditions should be removed when analyzing general measures of health.
6. Links between role-occupancy and health need to be revealed.
7. Prospective data that traces stages of illness behaviour from symptom perception through the entire course of care are needed to see how men and women differ in relevant psychosocial processes.
8. 'Women's health issues' can be addressed in the context of gender differences. More can be learned about women by comparing their illness experience and responses to men's than by studying them alone.

At the most basic level, which Finch (1984:33) describes as 'descriptive documentation', the assumptions behind use of gender as a variable remain unexamined, as they merely conform to established practice. However, when gender is used as an 'explanatory' variable, often in combination with other variables, a wider, more complex picture may be revealed, which brings in ideological and political considerations. For example, the work of Graham (1984), on the distribution of health and health care in households, highlights some of the shortcomings of research which is based on conventional assumptions about the public/private divide. Most of the research on men's health has centred on their occupational status and takes little account of their domestic roles and responsibilities:

'... thus a man's personality and employment status have been identified as the crucial variables. However, it is difficult to establish whether these factors operate as causes or effects of poor health' (Graham 1985:75).

Work on unemployment using the OPCS longitudinal study which began in 1971, shows that mortality rates are markedly higher among unemployed than employed men; this is particularly so in the case of suicides (Hakim 1979). In contrast, women's position in the labour market is seen in much of the research as just one aspect of the various roles which may have an effect upon their health. Employment, however, does appear to benefit the health of women as well as men (Arber et al 1985; Haavio-Manila 1986). Verbrugge highlights the inadequacy of the survey method in presenting the whole picture. The tendency is to focus on severe health problems and overtly public health actions, centred on service use. Thus:

'Problems which women experience more than men - the bothersome symptoms of non-fatal chronic conditions and acute conditions - are not captured well by national health statistics. These may be minor from a medical viewpoint, but they are not so in women's daily lives... therefore only a small part of the "iceberg of morbidity" is visible in health statistics or in clinical practice. Its gender hue varies, most likely being deeply feminine at the bottom and gradually fading until it is intensely masculine at the very top. The bulk of the iceberg is a feminine shade' (Verbrugge 1985:163).

Many studies in social research on gender differences in health concentrate on differences in reporting symptoms. Thus, for example, Mechanic (1976) found that medical statistics showed large sex differences in symptom recognition, with women reporting more symptoms than men, but subsequent clinical examinations revealed similar rates of 'illness'. Hibbard and Pope (1983) studied gender roles in relation to service use and illness orientation, concluding that whereas females were more likely to perceive symptoms than males, there was no apparent difference in illness behaviour and adoption of the sick role. Cleary et al (1982) found in their study that sex differences in utilization were linked with differences in reported health. These may be 'true' differences, or they may be 'artefacts' of reporting. The notion of what constitutes an 'artefactual' explanation

in the field of gender and health is explored by Popay (1989), who points out that artefactual explanations begin with the premise that the female excess of ill-health is most apparent on measures which are readily influenced by psycho-social factors. These include the assumptions that women are more sensitive to bodily discomfort than men, that they are more likely to attribute severity to symptoms, to act upon them and to adopt the sick role. The fact that these differences increase when self-reported health measures are employed, is often used as a criticism and a rationale for using more orthodox 'hard' data, incorporating statistics gathered by health professionals. Popay argues that the inherently positivistic assumption that subjective measures do not reflect 'real' differences, denies the importance of the 'meanings' men and women attach to the experience of ill-health:

'... these different categories of "meanings" should not be discounted as an artefact of the research process. Rather they should become the focus of research concerned to identify and understand the social processes which generate the differences. It follows from this line of argument that research on gender inequalities in health and illness should not be primarily concerned with whether the patterns of ill-health amongst men and women reflect "real" or "true" differences. Rather it should be exploring whether particular symptoms or experiences do "mean" something to men and women' (Popay 1989:6).

The nature of the social patterning of health and illness in men and women is extremely complex. The literature on marital status, for example, shows that divorced or separated men and women experience higher death rates and more ill-health than those who are married (Bibbington et al 1981; Thoits 1987); the difference is much less severe for women, which suggests that marriage may be a protective factor in terms of men's health. Studies of housebound housewives show high reports of both physical and mental illness, especially in the use of psychotropic drugs (Briscoe 1982; Kessler and McRae 1982). Some feminist interpretations of the female excess in mental illness argue that the

oppression women face is the crucial factor (Smart 1976; Carmen et. al 1981; Roberts 1985):

'Since men hold the power and authority, women are rewarded for developing a set of psychological characteristics that accommodate to and please men. Such traits - submissiveness, compliance, passivity, helplessness, weakness - have been encouraged in women and incorporated into some prevalent psychological theories in which they are defined as innate or inevitable characteristics of women. However, they are more accurately conceptualized as learned behaviours by which all subordinate group members attempt to ensure their survival... behaviours such as inhibition, passivity and submissiveness do not lead to favourable outcomes and play a role in the development of psychological problems' (Carmen et al 1981:1321).

Others point to the patriarchal domination of the medical profession making the diagnoses (Chesler 1972; Ehrenreich and English 1978; Showalter 1987).

Morgan (1986) emphasises how the theoretical tensions produced by the sex/gender distinctions tend to be echoed in the narrow, restricted use of gender in the research process, which does not allow for the complicated interaction between biology and culture:

'To adhere to a dichotomous construction of gender differences is to run the risk of reproducing, often unconsciously, stereotypical assumptions about men and women and of failing to do justice to the complex, paradoxical and sometimes contradictory understandings of gender in contemporary society' (Morgan 1986:35).

In order to encourage and expand the use of gender as a key variable in this 'explanatory' sense, Morgan provides some useful guidelines for the researcher:

1. Try to think beyond a simple male/female dichotomy in terms of gender differentiation.
2. Avoid using 'men', 'male' and 'masculine' as some kind of yardstick by which to measure female 'deviations' - men can be problematised as well as women.
3. In surveys, experiments, etc. always state the gender of the subject. If only one gender is used, do not assume any wider applicability.

4. Where gender is used in data analysis as an independent or test variable, always note non-significant findings as well as those deemed significant.
5. Do not automatically assume gender to be a key variable in the analysis of data and field material.
6. Remember the researcher has a gender as well: make this explicit, and attempt to assess how gender differences and similarities may have influenced the research situation (Morgan 1986:47-48).

In her review of over a decade of research in this field, Clarke (1983) suggests there are important conceptual errors around sex and gender embedded in much of the sociological research on health and illness. Like Stacey, she argues that these may be attributed to the male domination of both medicine and sociology, with the latter all too ready to adopt the prescribed models of the former, and thus likely to ignore 'the unique contribution which the sociological imagination provides' (Clarke 1983:64). The tendency to rely on positivism provides a limited and incomplete picture. A 'definitionist' perspective needs to be added; this would supply the subjective, everyday 'lived' experience of individuals, reflecting the multi-faceted nature of society.

In a critique of the implicit gender bias within the methodology of social research, Graham (1983:132) points out that the survey method reflects the dominant social values of the time it was conceived, namely the principles of individualism, equivalence and rationality. Although those values may accord with those which govern the operation of the state and the economy, it is more difficult to apply them to women's work in and for the family. Graham argues that although the use of this model distorts the lived reality of the everyday world, particularly the unequal social network of relationships which characterise women's lives, to reject it completely would be detrimental:

'Surveys, precisely because they conform to the rules of the public domain, have played an important part in raising the consciousness of those within the scientific and political world. Much of our knowledge about the

position and problems of women, knowledge crucial to the promotion (and preservation) of less divisive policies in the field of employment, health and education, derives from survey research. However, this method cannot be employed uncritically' (Graham 1987:135).

This returns us to the need for a rapprochement between different methodological approaches which emerged from the areas of work discussed in Chapter 1.

### **Gender and the context of feelings and emotions in the study of pain**

Within the context of the present study, the focus on gender is particularly appropriate with regard to the development of a phenomenological sociological approach to pain. Major links with the theoretical and methodological contribution to the sociology of health and illness have been made by feminist scholars over the last fifteen years, some of whose work has been cited in this chapter. Much of this work is grounded in ethnographic and humanistic traditions, and the essential feature is to emphasise the subjective (see for example Oakley 1981; Finch 1984; Smith 1988; Brannen 1989). An explicit agenda involved in employing a phenomenological methodology is that it aims to reveal the 'lay' voice rather than that of the 'expert' or professional. In turn, this enables the discussion of feelings and emotions to take place. Social science research has been consistently criticised for its neglect of these topics. Frustration was expressed by the psychologist Davitz (1969) two decades ago in his efforts to produce a language of emotions. This was a radical piece of work defining and describing in lay terms the experience of a variety of emotional states and the language used to refer to them. The author points out that most previous investigations had been concerned with predicting and controlling various emotional phenomena or identifying the antecedents, correlates and consequences of emotional reactions. Little attention was paid to the conceptualisation of these emotional components. Davitz goes as far as to say that:



'Poets and novelists have tried to capture and convey the meaning of emotional experience by a variety of linguistic devices, and of course there have been many instances of successful communication through a literary framework. By and large, psychologists have not been nearly so successful, though occasionally writers like James and Freud break through the bounds of conventional psychology and indeed convey what seem to be rich and valid experiences of emotional experiences. But academically orientated research psychologists have contributed little to this field, and many have taken refuge in the argument that an explication of emotional experience is outside the legitimate realm of scientific psychology. If one wants to learn something about the experience of guilt, anxiety or joy one might turn perhaps to Dostoevsky, Kierkegaard or Wordsworth, but certainly little is to be learned in this area from even the most careful study of Thorndike, Hull, Skinner, or any of the other major figures of academic psychology' (Davitz 1969:88).

Emotions are socially, as well as personally faceted, and their study raises fundamental issues for the mind/body relationship, as well as for the dichotomies of the individual/societal, masculine/feminine, instrumental/expressive, and physical/emotional. The importance of the emergence of sociology of emotions in the study of health and illness is given emphasis by Freund (1990), who maintains that the Durkhemian legacy of the non-reducibility of 'social facts' to biological 'facts' has resulted in a lack of acknowledgement of the body in sociology. To understand that biology can be socially constructed leads to a unification of the cognitive and the physical aspects of emotions, giving rise to:

'An existential-phenomenological perspective which emphasises subjectivity and the active expressive body [can be] used to bridge the mind-body-society splits that characterise both fields... a focus on the emotionally expressive, embodied subject, who is active in the context of power and social control, can provide a useful approach for studying distressful feelings, society and health'. (Freund 1990:452)

The work of Hochschild over the last decade has sought to establish the study of emotions, traditionally under the rubric of psychological expertise, as a legitimate field in the sociological arena. She points out that it is common practice amongst social scientists either to ignore emotion altogether, denying it as a tenable concept; or to

subsume it under other categories. She identifies a main reason for this as the fact that:

'... social psychologists believe the exquisite care they take to "avoid" discussing feeling, in order to focus ever more intently and narrowly on cognition, increases the scientific character of the work' (Hochschild 1983:201).

Hochschild goes on to highlight two strongly held notions which act to confuse and cloud our understanding of emotional processes:

1. An emotion such as anger or jealousy is seen to have an **independent** presence or identity, often given a bodily location or residency in a person or through time (e.g. love in the heart, envy in the bile; we talk of 'expressing', or 'storing' emotions which acquire an identity - 'that old jealousy' etc).
2. When 'possessed' by emotion we act **irrationally** and our perceptions are distorted - love is something we fall in or out of, we are in a thrall: we are taken over or consumed by anger, gripped by fear and so on. The implication is usually **negative**, and our cultural policy towards our emotional life is to watch out for this and manage it. However, such an attitude negates the positive aspects, such as comforting a crying child (Hochschild 1983:202-203).

Hochschild outlines two models regarding theories of emotion, the **organismic** and the **interactionist**. The organismic model sees emotion as an essentially biological process, so that the manner in which emotions are managed or labelled is seen as extrinsic and of less interest than how they are 'motored by instinct'. There is an inherent assumption of emotion having a prior existence distinct from introspection, and one which is passive and fixed. Hochschild (1983: 207-211) draws on the following theorists and their investigation of the origins of emotion:

1. The work of Darwin (1895) on instincts, which examined similarities in humans and animals, looking for universal rules of emotive gestures rather than culturally specific explanations.
2. The early work of Freud; for instance, the essay 'Formulations on the two principles of mental functioning' [1911] suggested that social factors merely 'trigger' biological releases and steer the expression of these reactions into customary channels. For Freud, anxiety is a model for all other emotions. The

implication is of an **unconscious** 'push-button' process, with no conception of emotions as being a subjective experience affected by social factors.

3. Within psychology, the James-Lange theory of emotion (1922), which proposes that emotion is the conscious reaction of the brain to instinctual visceral changes - James equates emotion with simultaneous bodily changes; for Lange, emotion is bodily change, and the experiential feeling is secondary to this. However, the experimental work of Cannon (1929) has significantly refuted the James-Lange theory; this involved surgical severing of the viscera from the central nervous system in dogs, and concluded that there was no alteration in emotional behaviour.

In the organismic model, whereas emotion always involves some biological component, social factors are interactive and may provide contesting outcomes. A critical psychological theory here is the 'two-factor' theory of emotion, according to which 'emotionality' results from interaction between cognitive and physiological factors (Schacter and Singer 1965). Advocates of this theory maintain that the perceived body-state is necessary for cognitive evaluation, and the labelling of physiological arousal is dependent on external cues as to whether it is interpreted as joy, despair or whatever. Support for this theory is found in experimental work in which subjects experiencing physiological arousal are unaware or misinformed of the cause of the excitation, and are likely to interpret the symptoms on the basis of the available cues, in contrast to subjects who are aware of the nature of the arousal and subsequently remain impervious to alternative cues (Cotton 1981; Reisenzein 1983).

However the proposition that physiological arousal is necessary for emotional labelling is not born out either in Schacter and Singer's own replication of their original study (1971), or in other studies (see, for example, Marshall and Zimbardo 1979), in which researchers found that after exposure to emotion-related environmental cues, initially unaroused subjects become 'emotional'. Again, definitions are problematic: for instance Thoits (1984) emphasises the distinction between observable gestures of

expression (such as body posture, trembling and so on, which are to some extent under voluntary control and thus can be disguised), and physiological changes, which can often only be detected by specialised techniques of measuring, such as blood pressure gauges or E.E.G (electro-encephelograph). For Arnold (1970), emotion is intimately connected to a cognitive process of situational appraisal and therefore affects integral features of information - the processing and coping capabilities of the organism - so that emotions are generated by evaluation of consequences. These may be implied either by sensory input or by retrieval of stored input in the form of images. There is a felt tendency to enhancement, away from harm.

The reductionist features of the organismic model are largely superseded for Hochschild by the **interactionist** model. Again, she assimilates the work of several theorists:

1. Dewey (1922:147), who proposed that emotion consists of '... an indefinite number of original or instinctive activities which are organised into interests and dispositions according to the situation to which they respond'.
2. The importance of social factors in the perception of emotion is echoed by Gerth and Mills (1964), who use a combination of theories of interaction from Mead, motivation from Freud and structural ideas from Weber and Marx, concluding that: 'Social interaction of gestures may thus not only express our feelings but define them as well' (Gerth and Mills 1964:55).
3. The work of Goffman (for example 1959), focusing on the interaction between the institution and the individual, with particular reference to stigmatisation and emotions of guilt and embarrassment. Goffman turns the biological focus on its head by maintaining that feelings contribute to interactions via the passive bodily self. We act behaviourally, not affectively, and the social system affects behaviour, not feelings. Subsequently suppression or repression of feeling in the social context is not unconscious, but consciously controlled and open to rules and norms which can be identified.

The emphasis is on the fact that emotions take place within a social context. Goffman's overarching use of the metaphor of acting, according to which individuals are interpreted as playing characters, played an important role in informing Hochschild's examination of the control of institutions over our personal feelings. She maintains that 'managing' feelings implies actively altering our emotional state and developing what she terms 'status shields' (1983:173) in order to protect attacks on our self-esteem. Having one's feelings ignored or termed as irrational has the subsequent impact of one's perceptions being invalidated, of being 'less than a person'. For instance, the feelings of a person of lower status are given less attention and weight than those of higher status, so they have fewer status shields with which to protect themselves. As a consequence, Hochschild maintains that any social theory of emotion must take into account the fact that this process cannot be without cost to the self. It must also recognize the biological basis of emotions, as the means by which we know how we relate to the world, and as therefore crucial to our survival:

'... when an emotion signals a message of danger or safety to us, it involves a reality newly grasped on the template of prior expectations. A signal involves a juxtaposition of what we see with what we expect to see - the two sides of surprise. The message "danger" takes on its meaning of danger only in relation to what we expect' (Hochschild 1983:221).

As a body of theory, the sociology of emotions is still developing, and requires further refinement and coherence. For instance, within Hochschild's social theory of emotion, there is an assumption of an inherent 'true self', which is conceptually problematic. Wilkins (1991) also cites the lack of an adequate epistemological critique:

'It is worth noting in passing that her (Hochschild's) approach leaves positivist methodology intact, making it possible to theorise emotion without looking methodologically at the researcher's emotions. For the researcher is still a "scientist", able to operate with affective neutrality. She thus fails to address some obvious implications of her own analysis' (Wilkins 1991:26).

Nevertheless, the theoretical input sketched out in the summary above, including Hochschild's concept of emotion 'work' - an emotional estrangement involving management of bodily states of arousal - has obvious implications for the Cartesian dualism of mind and body which permeates Western medicine, and which provides an important epistemological starting point for this thesis. It is also, as the following chapters show, highly salient to the understanding of perceptions of pain.

### CHAPTER 3.

#### THEORIES OF PAIN.

'Illness is the doctor to whom we pay most heed;  
to kindness, to knowledge, we make promises only:  
pain we obey.' (Proust [1871-1922])

Pain [from Latin **poena**, meaning penalty]:

1. An unpleasant feeling caused by injury or disease of the body.
2. Mental suffering.
3. [old use] punishment, e.g. on pain of death.

(Oxford Reference Dictionary; Oxford University Press 1987)

Although different conceptions of, and assumptions about, the nature of pain may underlie some of the gender differences in health and illness discussed in Chapter 2, these have, for the most part, been covert and unarticulated. As we have seen, social science researchers have to date devoted little attention to this important area within the study of health and illness. This chapter moves on to look at the different theoretical perspectives on pain which are available to inform research in this field, and argues that a phenomenological sociological approach to perceptions of pain would add to, and enhance, existing bodies of knowledge.

Theories of pain are traditionally dominated by biomedicine and concentrate on the neurophysiological aspects, both in diagnosis and treatment. However, since the latter half of the century there has been an increasing emphasis on psychological and cultural components, informing how pain is actually perceived by the individual. The idea of pain being an emotional experience, the obverse of pleasure, is in fact a much older conceptualisation than it being a physical sensation, and can be traced back to Plato's (429-347 BC) deliberations of extremes and opposites (e.g. hot/cold) etc. in The World

of Forms and developed further by Aristotle (384-322 BC), who went as far to declare that pleasure is merely the absence of pain. Literature, theology and philosophy abound with considerations of the nature of pain (see Tillich Systematic Theology vols. 1-3 1950-63; or Kierkegaard: Works of Love 1847, for example). At the turn of the century a furious battle raged between the neurologists Von Frey and Goldscheider over physiological aspects of pain specificity, whilst another viewpoint was put forward by H.R. Marshall, a philosopher and psychologist:

'... a plague on both your houses; pain is a quale<sup>1</sup>, that colours all sensory events' (Marshall 1895: 167).

Marshall maintained that there is a strong negative affective quality that drives us into activity associated with pain, rather than a mere sensation. In other words, we are compelled to do something about it and to act effectively in order to relieve it, beyond a simple reflex action. This places the affective processes parallel with sensory processes. The problems of measuring pain are vividly illustrated by Ludwig Wittgenstein during his considerations of logical positivism in Tractatus Logico-philosophicus (1921). He relates how he recorded the word 'empfinding' (toothache) continuously over several days in his diary, but questions whether the severity of the pain can be considered to be of the same quality in each instance, a fundamental dilemma of any measurement of pain.

The development of the hospice movement has contributed to the broadening out of concepts of pain (for an account of its history and development, see Mann 1988). One of the founders of the movement, Dame Cicely Saunders, in Care of the Dying (1976), advocated the notion of total pain, which includes psychological, spiritual, interpersonal and even financial aspects of chronic pain, as well as its physical aspects. Another

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<sup>1</sup> meaning emotional quality.



germinal influence contributing to changes in the conceptualisation of pain has been the work of Bonica, an anaesthetist in the US, who recommended in The Management of Pain (1953) that the treatment and understanding of pain would be best achieved through the co-operation of different disciplines. This was a radical notion arising in the era which produced the 'gate-control' theory of pain (Melzack and Wall 1965; see Figure 3.2).

The first pain clinic was set up in the USA in 1961 with specialists from thirteen different disciplines, aiming to collaborate in a non-hierarchical manner. The subsequent developments of pain centres throughout North America and Europe vary in provision and resources, but are characterised by a diversity in the organisation of work, medical specialities, working principles and therapies. A recent sociological study by Vrancken (1989) examined the theory and practice of pain in eight academic pain centres in the Netherlands. Five broad approaches to both theoretical and practical aspects of pain were identified:

### **1. The Somatico-technical Approach to Pain.**

Pragmatic approach, neuro-physiological model. Pain is organic, with much emphasis on classification; time is the only distinction between acute and chronic. Pain patients classified into: those with real pain, psychiatric disorders and malingerers. Therapy consists mainly of surgical procedures to eradicate, block or ease pain, and long-term use of narcotics. The development of secondary psychological complications is seen as second-rate. Patients are cured when 'objective' signs disappear.

### **2. The Dualistic Body-orientated Approach.**

Pain is result of organic, psychological and social factors. Nociception (i.e. purely sensory aspect) is the major factor, but other factors affect its final expression; fits with Gate-Control theory. Although no distinction between body/mind in theory, this does occur in practice - methodological dualism. Pain patients are of three types: chronic benign, chronic malignant, and chronic pain syndrome (CPS), differentiated by clinical history. Therapy depends on prevailing components; limits set by patients. Patients cured when pain is gone.

### **3. The Behaviourist Approach.**

Pain is chronic, intractable, and consists of overt actions which constitute pain behaviour.

Completely separate from acute pain which is mainly nociceptive and treated by physicians. Pain persistence is dependent on behavioural changes which are induced, maintained and reinforced by rewards from environmental factors; therefore treatment is by a psychologist. Pain patients may have investment or identity in the pain and/or the coping mechanisms have failed. 'Ideal' patient can be convinced pain linked to particular situations and willing to cooperate in programme. Therapy aims to minimise pain behaviour by setting achievable goals, rehabilitation and resocialization. Patient recovered when pain behaviour replaced by effective 'well behaviour'.

#### **4. The Phenomenological Approach.**

Pain seen as a complex of reactions and behaviours, triggered as a physiological self-defence under harmful conditions, but in its course independent of the initial event - the 'pain function'. Chronic pain is the result of an interrupted healing process, the pain sufferer is unable to find a place in the world, is unable to remain an integrated person due to ongoing pain experiences, so becomes a patient. Pain patients have a deficient organic life and remain in existential need, are angry and distanced from their pain. Therapy aims to return the person to human life by 'awakening' through human encounter. Patient recovered when emerges through encounter as a 'whole' person again and does not need doctors to remain healthy.

#### **5. The Consciousness Approach.**

Pain is a problem of consciousness, the part of the body which is in pain has become part of here-and-now awareness, and finally hurt to core of existence. Pain is incorporated into the meaning of being human. Pain patients in principle are anyone complaining of pain; in practice anyone with chronic pain. Therapy not specific, offers conditions for patient to work on her/his recovery; main prerequisite is possibility of establishing an interpersonal relationship, may be any form of treatment but preferably not invasive surgery. Patient recovered either by pain disappearing or by gaining enough insight to accept and manage. (Adapted from Vrancken 1989:435-444)

Integrated multi-disciplinary theories of pain may be more developed in the Netherlands than in Britain and the United States, and it must be acknowledged that the primary role of medicine is to treat and try to alleviate pain. However, traditional medical approaches are unable to claim complete expertise over the relief of suffering. Some problems are unable to be overcome, due to the dependence on the dualism of mind and body.

There have been efforts to 'demedicalise' the experience of pain by supplying evidence of the important role psychological factors play in pain perception and response.

Suggestion, distraction of attention, evaluation of the meaning of the situation and the feeling of control over potential injury have all been shown to affect physical as well as emotional pain. However these, and other relevant factors, also have cultural and sociological components which are given inadequate emphasis, especially in the development of research methods in the area of pain beliefs.

### **Traditional biomedical models**

The dominant traditional theory of pain, as described in most textbooks of neurophysiology, neurology and neurosurgery and taught to medical students largely as fact, is known as specificity theory. The proposition is presented as a straightforward one, and was first classically described by Descartes in 1664: a specific pain system carries messages from pain receptors in the skin to a pain centre in the brain as shown in Figure 3.1

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**FIGURE 3.1** Descartes' Illustration of the Pain Pathway (1664).

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



The specificity theory underwent little change until the nineteenth century, with the emergence of physiology as an experimental science. Muller's doctrine of specific nerve energies (1842) contributed an understanding of the sensory processes relaying information to the brain, and in particular, the differing qualities of sensation. However it was assumed that there was a straight-through system from the sensory organs (of taste, smell, sight, hearing and touch) to the brain centre responsible for the sensation. An eminent neurosurgeon of the times (Boring 1942) actually proposed that if the auditory nerve could be connected to the visual cortex, and the visual nerve to the auditory cortex, we would be able to see thunder and hear lightning! During 1894-5, a physician named Max von Frey published a series of articles in which he proposed a theory of the cutaneous senses. He expanded Muller's concept of a single sense of touch to four major cutaneous modalities - touch, warmth, cold and pain - each with its own special projection system to a brain centre responsible for the appropriate sensation. This theory was expanded during the next fifty years to form the basis of modern day specificity theory, with the separation of modality being extended to peripheral nerve fibres. Eventually a search was made for a 'pain pathway' in the spinal cord (Keele 1957), which is thought to be within the spinothalamic tract ascending in the anterolateral quadrant of the spinal cord. The location of the 'pain centre' is still a source of debate, but its location was proposed by Head (1920) as being in the thalamus, with the cortex being assumed to exert inhibitory control over it.

### **The Gate Control Theory**

Since the 1960s, the work of Melzack and Wall (1965, 1983, 1988) has challenged the model of specificity theory. During the first half of this century, influential research and effective forms of treatment were generated, but the theory is often presented

unproblematically, as if it can encompass all answers to pain problems. Wall and Melzack (1984) claim there are many implicit physiological, anatomical or psychological assumptions in specificity theory, which fail to provide answers to the following observations :

1. The relationship between injury and pain is highly variable.
2. Innocuous stimuli may produce pain.
3. The location of pain may be different from the location of damage.
4. Pain may persist in the absence of injury after healing.
5. The nature and location of pain changes with time.
6. Pain is not a single sensation but has many dimensions.
7. There is no adequate treatment for certain types of pain, especially idiopathic pains in which there is no sign of tissue damage and no agreed cause (such as low back pains and migraines).

Whereas physiological specialization for pain sensations can be identified, in that neurons in the nervous system are specialized to conduct patterns of nerve impulses that can be recorded and displayed, psychological specificity cannot be demonstrated in the same way. No neurons in the somatic projection system are indisputably linked to a single, specific psychological experience. Consequently there is no satisfactory definition which can encompass the diversity of perceptions:

"The word "pain" represents a category of experiences, signifying a multitude of different, unique experiences having different causes, and characterised by different qualities varying along a number of sensory, affective and evaluative dimensions' (Melzack and Wall 1988:161).

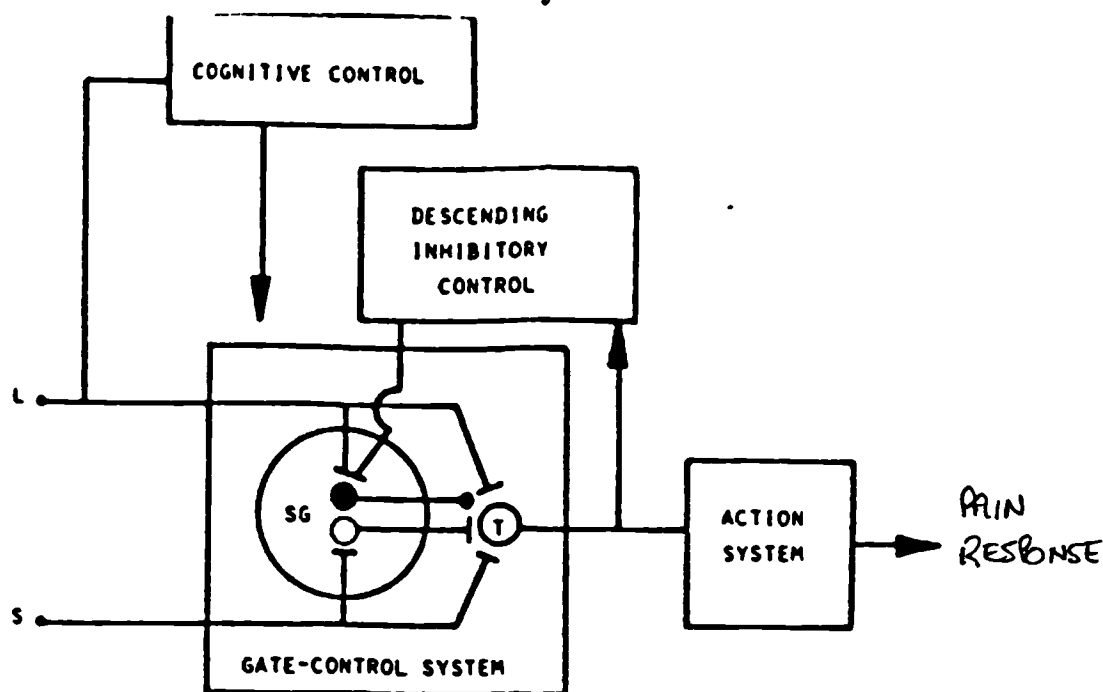
Melzack and Wall developed and refined the alternative model of the **Gate Control** theory, which hypothesizes that psychological and cognitive variables (heavily influenced by socio-cultural learning and experiences) have an impact on the physiological processes involved in human pain perception and response. The basis of the gate control theory is

that a neural mechanism in the dorsal horns area of the spinal cord:

'... acts like a gate which can increase or decrease the flow of nerve impulses from peripheral nerve fibres into the central nervous system. Somatic input is therefore subjected to the modulating influence of the gate before it evokes pain perception and response' (Melzack and Wall 1983:222).

These gates are proposed to be located in the substantia gelatinosa of the dorsal horns, where the peripheral nerve fibres enter and are joined with the central transmission fibres to the brain (see Figure 3.2).

**FIGURE 3.2 Melzack and Wall's Gate Control Theory.**



The gate-control model. This model includes "excitatory (white circle) and inhibitory (black circle) links from the substantia gelatinosa (SG) to the transmission (T) cells as well as descending inhibitory control from the brainstem systems". L = large nerve fibers; S = small nerve fibers; T = spinal cord central transmission cells to brain. Action system = "those neural areas that underlie the complex sequential patterns of behavior and experience characteristic of pain".

Source: Melzack and Wall 1965:972

The degree to which the gate increases or decreases sensory transmission is determined by the relative activity in nerve fibres, and by descending influences from the brain, so that cognitive or higher central nervous system processes such as attention, anxiety, anticipation, and past experiences exert a powerful influence on pain processes (Melzack and Wall 1983:230). Despite widespread discussion of the gate-control theory by researchers, and the conclusions of many that such a theory is useful in addressing formerly puzzling aspects of pain, clinical medicine has been reluctant to adopt the theory. There is a tendency to remain in the traditional biomedical paradigm which divorces mental from physical states, and attempts to attribute single symptoms to single causes.

### **Psychological approaches**

Within the discipline of psychology, the gate-control theory has been influential in expanding the rather narrow focus on pain tolerance and thresholds, the dominant approach within the study of pain perception. The study of perception within psychology is concerned with the extraction of perceptual cues from sensory inputs in order to distinguish and convert them into meaningful precepts. It is heavily embedded in psychophysics, using experimental methods which inflict (often noxious) stimuli on subjects. From the mid-nineteenth century onwards, Weber and others carried out investigations of **psychological** responses to **physical** stimuli, attempting to chart the limits of sensation using analogies from physical science, which equated individual sensations with atoms. Subsequently, a body of work on thresholds has emerged. A **threshold** is defined as the minimum amount of stimulation to which observers will report they have experienced a sensation. It is measured by the experimenter increasing the intensity of a stimulus, such as a pinpoint of light or touch on the skin, until the observer reports an

awareness (Greene 1990). When conducting experiments, it was noted that sometimes the observer would report a sensation and sometimes not. This led to the development of the concept of an **absolute** threshold, defined as the observer reporting the stimulus on 50% of occasions. The stimulus may be less noticeable under different conditions, or different parts of the body, and the term Just Noticeable Differences (JNDs) indicates distinct different sensations, which may be very close together on sensitive areas, but quite far apart on those less so, for example, the back of the neck. Weber's Law states that the difference in intensity between the two stimuli has to be proportionately the same for a JND to be reported (Greene 1990: 237).

These methods claim to have much success in predicting responses to sensory inputs. The measurement of thresholds has informed the bulk of research on pain perception, which again concentrates on the sensory component or **nociception**, and is based upon the principle of a continuum of sensation which becomes painful to a threshold which is intolerable. 'Threshold' refers to the first painful perception of the stimulus, whereas 'tolerance' is the point at which the subject reports being unable to tolerate the stimulus any longer (Elton Stanley and Burrows 1983). The relationship between the two is uncertain, as precise measurements are difficult to obtain, and the Signal Detection Theory (Gregory 1972) acknowledges the existence of a fluctuating amount of background activity in the central nervous system which would give rise to a range of magnitudes of reporting thresholds.

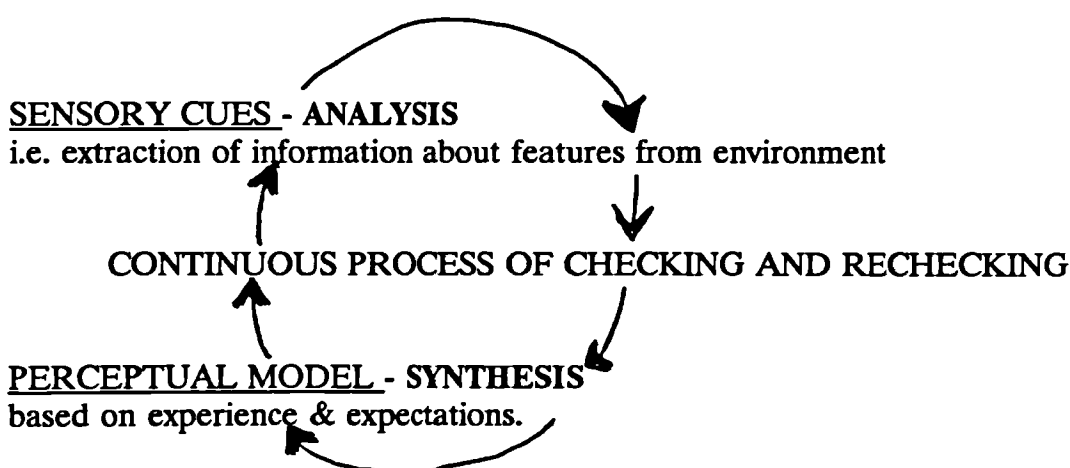
The focus on psychological factors in pain perception has led to many experimental studies. Most of which are clinically controlled trials, involving the infliction of pain on subjects to measure pain threshold and tolerance. Hardy et al (1952) conducted numerous experimental studies of pain perception, concerned mainly with skin



temperature. They developed an apparatus to test these called a **doloremeter** (dolor = pain). Their research indicates that the threshold temperature (i.e. the skin temperature reached at the time of report of minimum pain) lies between 43 and 47°C which they maintain is independent of sex, age and cultural background. Attempts at replication (see Lele et al 1954) show a wide variation, with temperatures as low as 36°C producing reports of pain for some subjects, indicating that this form of measurement is problematic. The ethical implications of inflicting pain on subjects in these studies are rarely discussed.

One obvious general difficulty is that the experimental nature of these studies does not allow the social context to be taken into account. Most of the psychological research on pain perception is weighted heavily towards sensory cues, with little emphasis on the subjectivity of the perceiver, despite the development of theories such as the cyclic model of perception (Neisser 1976; see Figure 3:3).

**FIGURE 3.3 Neisser's cyclic model of perception.**



Source: Neisser 1976:214

Although more recent research encompasses more complex questions, such as the relationship between the patient's 'mental state' and pain, the use of experimental techniques appears to result in a process that is 'dehumanising'. For example, evidence has been produced to demonstrate the positive relationship between anxiety and pain, often using measures of pain thresholds produced by pain stimulators. Dougher et al (1987), investigating the pain thresholds of 80 undergraduate students, describe how the painful stimulus was produced:

'A modified Forgione and Barber (1971) focal pressure pain stimulator was used. The device consists of a dull lucite knife edge (.6mm thick) applied at a continuous pressure (1000 g) to the second phalanx of the participants' fingers. The device produces a dull aching sensation that gradually builds into a throbbing pain' (Dougher et al 1987:260)

The participants were given anxiety-eliciting statements prior to the stimulus, and findings showed that pain-specific anxiety led to increased perceptions of pain on a seven-point self-reported scale.

Less intrusive methods such as observations of pain behaviours during physical examination, ratings of pain, measures of activity and medication level were used by Keefe (1986) to show the degree to which depression predicts pain and pain behaviour. The findings indicate that depression is an important factor that needs to be considered when evaluating the clinical significance of pain and pain behaviour in patients with low back pain. In similar vein, Merskey (1965) argues that hysteria has a strong correlation with pain: in his study 75% of patients with heart symptoms caused by anxiety complained of pain; out of a sample of patients attending gastrointestinal clinics, 75% complained of pain, and 38% of those had psychological disorders without associated evidence of organic disease. He found conversion symptoms of pain associated strongly with neurosis and hysterical conditions rather than with psychotic illness and brain

damage, and the reported rates of pain were much higher in psychiatric out-patient clinics than in-patients. Merskey and Spear (1967) define the distinction between 'organic' and 'psychogenic' pain as follows:

Organic pain is '... pain which is largely dependent upon irritation of nerve endings or nerves, or else due to a lesion of the central nervous system, including some possibly patho-physiological disturbances like causalgia<sup>2</sup>' (1967:19).

Psychogenic pain is '... either pain which is independent of peripheral stimulation or damage to the nervous system and due to emotional factors, or else pain in which any peripheral change (e.g.muscle tension) is a consequence of emotional factors' (1967:19).

Although this distinction may be useful, Elton et al (1983) advise against emphasising it, as they point out that all 'organic' pain has a psychological component and simplistic links between emotional factors and 'psychogenic' pain are inconclusive.

Another psychological variable given much emphasis in the literature is that of self-esteem. Engel (1958) investigated the childhood histories of his patients and presented a profile of the 'pain-prone' personality, which, he claimed, suggested an 'ambiguity' towards pain, supposedly discernible by any of the following features:

- (a) Childhood needs: pain is linked to crying and being soothed by the maternal figure.
- (b) Punishment by parents: pain relieves guilt and produces expiation, forgiveness and reunion.
- (c) Aggression and power in childhood: self-inflicted pain being is as a form of control over aggression.
- (d) Loss of a loved one.
- (e) Pain enjoyed in a sexual context.

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<sup>2</sup> Pain referred to in the distribution of a cutaneous nerve which persists long after an injury to that nerve.

The notion of the pain-prone personality has profoundly influenced perceptions of the emotional component of pain. It has also led to the categorization of pain lacking well-defined physiological causes as 'imaginary'. The chronic pain syndrome, defined by Kortaba (1983) as an ongoing experience of embodied discomfort that fails to heal either naturally or to respond to normal forms of medical intervention, becomes difficult and frustrating for both patient and physician. The only effective treatment is seen to be through either a psychiatrist or behaviourally orientated psychologist (Soluriac et al 1968). This, however, is only viewed as possible with the well-motivated, by eliminating so-called 'rewards' which have, in the past, resulted from pain behaviours, and substituting what are described as more 'constructive' activities.

The behavioural approach is substantiated by increasing evidence that social learning is instrumental in the development of meanings for, and attitudes towards, pain. Learned values and attitudes affect attention to painful stimuli and memories of prior pain experiences. Attitudes, expectations, experiential meanings and appropriate emotional expressiveness are learned through observing the reactions and behaviours of others. The first source of social comparison and learning is the family, where adults transmit their values and attitudes to children. For instance, Shoben and Borland (1954) found that children's dental phobias were directly influenced by the attitudes of their families toward dental care. The influence of social modelling and group pressure on pain tolerance levels is demonstrated by Buss and Portnoy (1967), and by Crain and Neidermayer (1974), implying that learned attitudes and values affect both the perception of the intensity of the pain stimulus and also the memory of the experience. Tyrer (1986), a consultant psychiatrist working at a pain relief clinic, describes learned pain behaviour as 'symptomatic' when the patient describes more pain than can be related to any

pathological process:

**'The recognition of learned pain behaviour depends on paying attention to the relation between pain behaviours and their apparent consequences - not on eliciting a multitude of inappropriate organic signs or symptoms. Certainly the patient should be seen and examined in detail but those closest to him should also be seen and interactions between them and the patient observed. The transaction between the patient and the doctor may not be representative' (Tyrer 1986:1).**

In other words, if an action produces a reduction in pain, it is repeated, and may be reinforced by parents, spouses or others in the immediate environment. A number of studies have highlighted particular aspects of past experience and personality factors which may predispose more sensitivity to pain perception, such as the adoption of an adult role in early childhood (Gentry et al 1974), and being brought up in a household with a chronically sick relative (Blumer and Heilbronn 1974).

Generally, the psychological literature reviewed has both theoretical and methodological limitations, as these types of studies can be criticised for their tendencies to isolate people from the contexts in which they live. Maslow (1987) heavily criticises the limitations inherent under the rubric of perception in psychology in the following terms:

**'Perception is too much the limited study of mistakes, distortion, illusions and the like. Wertheimer would have called it the study of psychological blindness. What are the factors that make it possible for healthy people to perceive reality more effectively, to predict the future more accurately, to perceive more easily what people are really like, that make it possible for them to endure or to enjoy the unknown, the unstructured and ambiguous and the mysterious? Why do the wishes and hopes of healthy people have so little power to distort their perceptions? The healthier people are, the more their capacities are interrelated. This holds also for the sensory modalities' (Maslow 1987:67).**

In order to develop a more sophisticated model of pain, which locates individuals within their social and cultural contexts, a more structural analysis is needed.

### **Cultural meanings**

Beecher (1959) was one of the first to stress the impact of the cultural meaning of pain on its perception and response. He found that injured combat soldiers, during World War II, reported little or no pain associated with their wounds, despite serious tissue trauma. Having established that they were actually capable of feeling pain, he also observed that they did not appear to be in shock, and concluded that their perception of pain had been altered by the motivation of being able to return home.

The contribution of medical anthropology in this field has extended the analysis of pain considerably. Helman (1979:95) puts forward the following propositions:-

1. Not all social or cultural groups respond to pain in the same way.
2. How people perceive and respond to pain, both in themselves and others, can be largely influenced by their cultural background.
3. How, and whether, people communicate their pain to health professionals and to others, can be influenced by cultural factors.

In order to clarify whether pain is expressed as a symptom or not, Helman suggests a distinction between private and public pain. Reactions to pain are not simply involuntary and instinctual, but take place within a social context, and contain a voluntary component in that action to relieve pain may or may not be sought, and the help of others enlisted or not enlisted. Certain cultural or social groups may hold stoicism in esteem, so that keeping pain private, or expressing it publically, may be desirable within a particular social group's major values. Zola's classic study (1966) of reactions to illness by Italian-Americans and Irish-Americans, using non-participant observation in the Accident and Emergency department of a large New York hospital, is still quoted as the best-known study of the relationship between culture and pain. The Italian response in the

study was identified by Zola as a defence mechanism to cope with anxiety by expressiveness and expansiveness, by repeatedly over-expressing it and thereby dissipating it, whereas the Irish response was to ignore or play down the symptoms, particularly of pain - a different type of defence mechanism. A similar study by Zborowski (1952) examined the cultural components of the experience of pain amongst Italian-Americans, Jewish-Americans and largely Protestant 'Old Americans', again revealing marked differences between the groups. The Italian group were described as laying great emphasis on the immediacy of experiencing pain, especially on the actual sensation, but as quickly forgetting their suffering once it had gone. The Jewish group were said to be mainly concerned with the meaning and significance of the pain in relation to their health and welfare - their anxieties were concentrated on the implications for the future of the pain experience. In contrast the 'Old Americans' were described as much less emotional and more detached in reporting pain, often having an idealised picture of how to react, and trying to avoid 'being a nuisance'.

These studies can be criticised for reinforcement of ethnic stereotypes, and they are also criticised by Bates (1987:48) for their failure to control for the influence on pain intensity of other medical, psychological and sociocultural variables. However, they do demonstrate the fundamental need for the social identity of the subject to be taken into consideration. Central to this process is the formation of pain beliefs, which are thought to be a major component in the perception of pain. Williams and Thorn (1989) define pain beliefs as:

'A subset of a patient's belief system which represents a personal understanding of the pain experience... these beliefs develop through the assimilation of new information (e.g. diagnoses, symptoms, emotional reactions) with pre-existing meaning and action patterns held by the patient' (Williams and Thorn 1989:76).

Their work suggests that personal beliefs about affliction may well be discordant with scientific understanding, and vary from representations offered by health professionals. Such discordance may affect compliance with methods of chronic pain treatment. Williams and Thorn developed a Pain Beliefs and Perception Inventory (PBAPI), the use of which revealed three dimensions of pain beliefs, namely self-blame, perception of pain as mysterious and beliefs about the duration of pain. These were found to be associated with subjective pain intensity, poor self-esteem, somatization and psychological distress.

The sociological contribution to the understanding of the processes involved in pain perception and beliefs has been notably lacking. Very recently there has been a movement within medical sociology towards establishing a discourse - an integrated conceptualisation and presentation - around pain. For example, an existential approach is used by Kortaba (1983) in order to reconstruct the psychological process of becoming a 'pain-afflicted' person. Analyses of self-perceptions are made in order to trace the continuity of personal identity. Using pain biographies of people who have sought treatment, Kortaba (1983:243-244) identifies three stages in this process:

1. 'Onset' - perceived to be transitory, able to be dealt with by diagnosis and treatment. Pain is diagnosed as 'real' by physician, having a physiological basis.
2. 'Emergence of doubt' - treatment may not work, increase in specialist consultations, but patient still in control as seeking best care available.
3. 'Chronic pain experience' - after shortcomings of treatment patient may return to lay frame of reference, then the chronic pain subculture.

In the emergence of the 'chronic pain career' two themes emerge - the clinical and the experiential. These themes are echoed in Mishler's (1984) delineation of the two voices in the medical interview - the 'voice of medicine' (biomedical, clinical information) and the 'voice of the lifeworld' (social, contextual information). Although these experiences are not mutually exclusive of each other, there is an implied hierarchy in which the



former is often assumed by health professionals to be routine and normative, whereas the latter is more likely to be perceived as irrelevant, or even disruptive. Kortaba claims to have tapped into the 'fundamental essence' of the chronic pain experience. Whilst acknowledging the potential of this approach, Bazanger (1989) also criticises its limits, namely the contextual dimension and the possibility of economic, social and cultural variations, and the risk that in the end the pain defines the person rather than the other way round. In an exploration of the phenomenological approach, she notes how medical sociology has begun to make enquiries into the connotation of 'living with' illness and concentrate on the experience of the sufferer. This restores the illness to the patient, which she claims is a welcome reaction to what she terms as the 'medicocentrism' of theorists such as Parsons and Friedson.

An existential viewpoint also permeates through to therapeutic approaches, as in the following address by Carmichael (1985) to an multi-disciplinary audience of therapists working with people in chronic pain. She advocates using the pain rather than becoming a passive victim to it:

'Constructive use of pain can only be achieved if we can see the pain as an ally - if we can confront it. The natural response is to express; the social response is to suppress. Fearing it, distancing it, protecting ourselves from it, makes it stronger. The more you push it away, the more it pushes its hooks into you... you need to confront it, enter into a dialogue with it, ask it what it's saying to you... anger can provide a substitute for pain, but may be used destructively rather than constructively... permanent anger is a stuck form of pain. What is useless is denial or avoidance of pain; we need, as Camus advised in The Plague, to root ourselves in our distress' (Carmichael 1985:9).

Perhaps the most salient role for sociology to play in the understanding of pain is to deconstruct the rigid objectivity of the bio-medical model and restore pain to those who experience it; as a discipline, sociology is able to encompass the necessary diversity and flexibility of inquiry and methods. An emphasis on the power of the subject through

the work of Foucault (see Chapter 1) has led to one of the most important developments in medical sociology. Using the notion of 'le regard', or the medical gaze, to examine the meaning of obstetric pain, Arney and Neill (1982) found that there was a historical change in its conceptualization; in the pre-war period pain was one-dimensional and confined to the body, but in the post-war years it developed social and psychological dimensions. Using case studies and an epidemiological survey investigating dental pain, Nettleton (1989) employed a Foucaultian analysis to explore the relationship between the understanding of the person experiencing pain and the medical contribution. Central to this analysis are the levels of power and knowledge which permeate the two 'voices' and whose function:

'... transcends professional and disciplinary boundaries and is a process which is far more subtle and fundamental than one of the accumulation of increasingly sophisticated knowledge or of political manoeuvrings by interested individuals or groups who wish to see a more humane system of health care' (Nettleton 1989:1189).

Nettleton stresses the importance of the role of fear, concluding that the movement of pain from the anatomical space to the psycho-social space has resulted in a major conceptual shift which seeks clues and answers in social relationships, rather than in anatomy.

One of these social relationships forms a central focus of this thesis, namely the role of gender. Historically, pain has not been a subject of intense scrutiny in terms of gender difference research. Epidemiological patterns appear to repeat the pattern of sex differences in morbidity. For instance in the U.S., women report a higher incidence of both temporary and persistent pain than men (see Crook et al 1984; Von Korff et al 1988), and more women than men seek treatment for chronic pain (Helkimo 1976; Margolis et al 1984). Contemporary research (Feine et al 1991) concerned with these

differences retains the focus on experimental laboratory testing, but does acknowledge there may be complex factors involved:

'... these differences may be due to sociological factors which demand stoicism in males and allow expression of pain in females, or they may be due to physiologic or anatomical differences between the sexes' (Feine et al 1991:255) .

The research which has taken place appears to be almost exclusively under the rubric of psychophysical investigation. Here gender is not viewed as a variable of any significance in the perception of pain (see Hardy et al 1952; Chapman and Jones 1944; Spear 1966). However attitude surveys concerned with analgesia conducted by drug companies repeat the view of **both** sexes that women are much more able to cope with pain than men. For instance, a survey on beliefs about pain (Nurofen 1989) carried out structured interviews of married and heterosexual cohabiting couples over 18, from different areas of the U.K. (specified as Scotland, the North, Midlands, Wales and the South). Of 531 men and women, 229 were classified as Social Class ABC1 and 302 as C2DE; they were asked to rate their pain threshold and that of their partner on a scale from very low to very high. There were no gender differences whatsoever, but when respondents were asked the question: 'Do you believe that women are better able to tolerate pain than men?' 75% of the sample (64% of men and 86% of women) said yes, 15% (20% men and 11% women) thought 'both equally'; the same proportion said they did not know or did not answer and only 10% (16% men and 3% women) said 'no'. The same question was previously asked in a similar cross-national study in the U.S. (Squibb 1987). This interviewed 2,500 married/cohabiting couples, and found that 82% of the sample felt that the female capacity to cope with pain was much higher.

A more detailed search of the more recent medical and psychiatric literature on pain perception reveals something of a controversy over gender differences. Using a variety

of noxious stimuli, such as heat, cold, shock and pressure, some studies confirm the no difference hypothesis (see Lawlis et al 1984; Neri and Agazzani 1984). Other studies, using similar techniques, indicated that women have lower tolerances. For instance, Notermans and Tophoff (1967) found that men were able to tolerate higher intensities of electric shocks than women, but that the detection thresholds did not differ. A study of the reactions of 41,119 men and women by Woodrow et al (1977) showed that men were able to sustain more pressure on the Achilles tendon. Lower pain tolerance or thresholds in females are echoed in other studies (see Otto and Dougher 1985; Dubreil and Kohn 1986).

### **Conclusion**

These contradictions are indicative of inherent tensions already discussed regarding the conceptualisation and measurement of pain. However, to a considerable extent, the discrepancies in the findings of these studies can be explained by different methodological approaches. Thresholds and tolerance levels are measured using experimental studies carried out in laboratories under controlled conditions, in which one variable, often involving the infliction of a noxious stimulation, is manipulated at a time to demonstrate psychophysical laws. The subjects are usually young and healthy university/college students who are unpaid or paid volunteers. Ethical issues concerning the infliction of the pain stimulus are often justified by the emphasis on consent and control, as in this example from Elton et al (1983):

'... the subjects know that no harm will come to them as a result of the experimentally induced pain. They also know they are basically in control of the situation, and that they can terminate the nociception as soon as they are no longer prepared to endure it' (Elton et al 1983:63).

There are other problems with these studies, apart from the substantial ethical considerations. They can also be criticised on the grounds that what they offer is an

artificial and limited approach to the investigation of pain. Experimental pain is not equivalent to clinical pain, as the 'reaction component' which Beecher (1959) claims is inherent in all processing of pain perception in 'real' life, is inevitably distorted.

The fact that a pain threshold must be articulated means it is inseparable from language and culture; consequently to ascribe objective measures to something that has been repeatedly shown to have such overtly subjective components is inevitably problematic, as indeed is the notion of objectivity itself in the process of perception. Individuals personalise their analysis of what they see around them; the process of perception is **subjective** and **selective**. Any study involving perception should also be aware of subjectivity bias on the part of the researcher, and the dilemma of distinguishing between **interpretation, perception and inference**.

The following account by Bertrand Russell (1945) illustrates some of the problems neatly:

'You say "What can I see on the horizon?" One man says "I see a ship." Another says "I see a steamer with two funnels." A third says, "I see a Cunarder going from Southampton to New York". How much of what these three people say is to count as perception? They may all three be perfectly right in what they say, and yet we should not concede that a man can "perceive" that the ship is going from Southampton to New York... he is using inference. Apart from experience, he only sees a queerly shaped dark dot on the blue background and experience has taught him that sort of dot "means" a ship... but it is by no means easy to draw the line; some things which are, in an important sense, inferential, must be admitted to be perceptions' (Russell 1945: 78).

The focus on thresholds appears to be the only issue concerning gender that has received much attention in pain research. However, the studies examined show conceptual and methodological limitations, particularly in the area of pain beliefs. Once again, the use of a more phenomenological, subjective approach is indicated. This should enable subjects to include their feelings and emotions, and could subsequently explore

whether pain perception is, indeed, fundamentally a gendered phenomenon.

## CHAPTER 4.

### AIMS AND DESIGN OF THE RESEARCH.

Throughout the timespan of studying for this PhD, the subject of gender differences in pain met with an almost universal response from both women and men, along the following lines:

'Well, we all know the answer to that one, you don't need a flamin' PhD to know - its common knowledge that women cope with pain far better than men' (Male window cleaner aged 30).

The existence of such an entrenched view is intriguing, as the academic literature on pain indicates that, on the whole, and, as was discussed in the last chapter, gender is not viewed as a variable of any significance in the perception of pain. Although theoretical approaches to pain have broadened out since the 1960s, becoming more eclectic and multi-disciplinary, and encompassing both phenomenological and hermeneutic philosophies, these developments do not so far appear to be reflected in the methodological design of studies.

The central aim of this research is to explore how men and women perceive, evaluate and act upon their own symptoms of pain, and whether social characteristics, particularly gender, are seen to be important in affecting this process. Existing research suggests that the understanding and interpretation of personal beliefs about affliction and pain is a fundamental component of pain perception. These beliefs include emotional, psychological, sociological, philosophical and existential aspects, as well as the sensory dimensions. A central hypothesis of the present research is that the mind/body dualism and the dominance of a somatic ideology inherent in medicine tends to define emotional

expression in experiences of pain as socially undesirable, whereas attributes such as stoicism tend to be valued. It is further hypothesised that this moral evaluation may be gendered. Methodological issues are raised by the above considerations, as traditional clinical or experimental studies are unable to encompass the more abstract and subjective aspects of pain beliefs. There may be variation in acute or chronic, physical or emotional components, depending on the individual's experience. Hence, a principal aim of this study is to allow the subjects to define for themselves what they mean by 'pain'. The inclusion of subjective approaches in the research design makes even more apposite the focus on gender, as theoretical and methodological work within the sociology of health and illness by feminist scholars over the last fifteen years has highlighted the links between qualitative methodology and the representation of gendered experiences. (It is recognised, however, that gender does not operate in isolation, being cross-cut by other social characteristics such as race and class.) In addition, much of this work is grounded in ethnographic and humanistic traditions, an essential feature of which is to emphasise the subjective and to reveal the 'lay' voice rather than that of the 'expert' or professional. Feminist critiques within medical sociology have identified a longstanding and unquestioning acceptance of the values and norms of the existing society which are reflected in medical practice and provision (see Clarke 1983). As a discipline, sociology has the flexibility and 'methodological imagination' required to allow insights into the complexity of pain beliefs, as located in the context of such issues. Sociologists have consistently argued that the blending of quantitative and qualitative approaches can be complementary, and that the logic of triangulation lends itself to one set of data being 'checked' against another (Bryman 1988). This is the approach used in the design of the present study. Central to the research design are three different, but complementary



methods of data collection:

1. A questionnaire survey.
2. An in-depth interview.
3. A discussion of visual imagery portraying various types of pain experience.

Each method is discussed in detail below.

### **The questionnaire survey**

The questionnaire phase of the study had two main objectives. First, to examine beliefs about health, illness and pain within a larger population than could be included in an interview sample (bearing in mind the time and cost-constraints of a doctoral study). A second objective was to suggest themes which could be examined by means of in-depth interviews with a smaller sample.

The questionnaire sample was obtained by writing to a number of G.P. surgeries and health centres in North and Central London between October 1988 and March 1989 and explaining the aims of the research. Four practices responded that they felt unable to take on any more research projects as they were involved in on-going studies. In four cases I was invited to give presentations at clinical meetings, which served the additional purpose of supplying outside feedback to the research design. On the whole, the reaction of these meetings was favourable, although one G.P. expressed reservations about the design, suggesting that it should be more 'clinical', for instance choosing one particular type of pain such as back pain and exploring it using matched pairs of men and women. The clinical feedback was especially useful in terms of the questionnaire design. (The original draft was composed mainly of open-ended questions and was piloted on friends and colleagues.) It was eventually agreed that I would be able to procure a sample from a practice in Kilburn, North West London on the understanding that patient records,

names and addresses would only be obtained with the patient's consent. The age/sex profile of the practice on 31.03.89 was as follows:

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**TABLE 4:1            AGE/SEX    PROFILE    OF    KILBURN    G.P.    PRACTICE  
POPULATION**

<b>AGE</b>	<b>MEN</b>		<b>WOMEN</b>		<b>TOTAL</b>	
	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>
0-4.11	6	(335)	5	(315)	5	(650)
5.0-16.11	12	(687)	10	(652)	12	(1339)
17.0-24.11	12	(676)	13	(879)	13	(1555)
25.0-44.11	43	(2444)	45	(2916)	44	(5360)
45.0-64.11	21	(1180)	17	(1109)	19	(2280)
65.0-74.11	4	(249)	5	(296)	4	(545)
75+	2	(151)	5	(298)	3	(449)
<b>TOTAL</b>	<b>100</b>	<b>(5722)</b>	<b>100</b>	<b>(6465)</b>	<b>100</b>	<b>(12187)</b>

---

Kilburn is a multi-racial inner-city area with a very mixed social profile, including both deprivation and gentrification in housing and other services. There is a large Irish population, many of whom are third generation, and also a sizable part of the community who are second or third generation to parents who originally emigrated from the Caribbean. Many of the respondents who described themselves as 'mixed race' have parents from either or both of these two cultures.

It was decided to aim for 100 cases in order to provide a realistically manageable sample which would yield meaningful statistics. The original intention was to sample on the basis of the practice profile, to secure a group of respondents who would be representative of the practice population. Young people under the age of 17 were excluded, in order to avoid complications with parental consent. A postal survey was planned following the recommendations of Cartwright (1984) and Oakley et al (1990),

who have achieved high response rates with postal health surveys. Cautiously aiming for a response rate of 50%, 200 questionnaires were sent out by calculating the proportions in each group and randomly selecting names and addresses according to the age\sex register as follows:

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**TABLE 4.2: AGE/SEX PROFILE OF POSTAL QUESTIONNAIRE SAMPLE**

AGE	MEN		WOMEN		TOTAL	
	%	(N)	%	(N)	%	(N)
17.0-24.11	15	(14)	5	(16)	15	(30)
25.0-44.11	52	(48)	54	(58)	53	(106)
45.0-64.11	28	(25)	23	(25)	25	(50)
65.0-75+	5	(5)	8	(9)	7	(14)
<b>TOTAL</b>	<b>100</b>	<b>(92)</b>	<b>100</b>	<b>(108)</b>	<b>100</b>	<b>(200)</b>

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[Random sample to be based on GP practice population of 10189 men and women aged 17+]

The final version of the questionnaire comprised mainly pre-coded questions and is reproduced in Appendix 1. It covers the following broad topics:

1. Medical history and general health beliefs.
2. Worst experience of pain (using pain scales to evaluate past experience).
3. 'Coping' behaviour in illness and pain i.e. action taken, whether treatment was sought, satisfaction with outcome.
4. The importance of the role of emotions in perceptions of pain.
5. Expectations relating to the ability of men and women to cope with painful experiences - whether there are differences and why.
6. Open space was given for respondents to include anything they thought was relevant to their experiences of, or beliefs about pain.

As a central hypothesis of the thesis was that social factors may give rise to variations in pain perception, demographic details in addition to gender and age were collected, including occupational status, household type and tenure, ethnic background, age of leaving school and qualifications gained.

The questionnaires were sent out by the practice manager, as this was considered 'ethically' preferable to allowing me direct access to names and addresses. Unfortunately, these efforts met with little success. Out of the 200 questionnaires which were sent out in June 1989 with introductory letters from the surgery, only nineteen replies had been received by the end of July. A reminder with a duplicate questionnaire sent in August only yielded another thirteen responses, giving a total of thirty-two (of which only four had been filled in by men).

Although postal questionnaires have produced good response rates in other health surveys, Cartwright (1984) observes that interest in, and commitment to, the subject is needed. It may have been the case that the questionnaire presented pain in too broad a manner, or that it is too sensitive as a topic. Other factors could have contributed to the poor response rate, including the tendency of response rates to be consistently lower in the London area. However, a significant factor was that 65 questionnaires - 33% of the initial mailing - were returned marked 'not known at this address'. When this was reported back to the practice manager, the records were cross-checked from the computer and only three changes of address had been notified. The lack of reliability of records in inner-city practices has been noted by others (Jarman 1983). As well as raising policy issues, this was a valuable lesson in terms of using G.P. records for research purposes, as previous concerns expressed by members of the practice had centred on the ethical issues rather than any practical difficulties.

Following the low response rate to the postal questionnaire, it was decided the most sensible strategy would be to abandon the postal survey and devise another way of distributing the questionnaires. Permission was obtained for me to approach patients in the surgery waiting-room to take part in the research, again on the understanding that contact remained totally confidential and anonymous unless the person concerned volunteered their name and/or address. From September until mid-November 1989 I attended the surgery whenever possible, ensuring that different days of the week and different times of the day were covered (for example, morning and evening surgeries). I was allowed to sit at the reception desk and to approach anyone who registered for an appointment to see if they would be willing to complete the questionnaire. In this way I was able to collect a total of 75 cases. Only 5 people among those I approached refused to participate. The cases were sampled to be as representative as possible of the practice profile (see Table 4:1). In eleven of these cases, I read the questionnaire aloud to the person concerned and filled it in for them, as they either had visual impairment or other difficulties with reading, or else English was not their primary language and some explanation of the questions was needed. The other respondents completed the questionnaires themselves, usually within the time they waited to see the doctor. (I made it clear that I was available if there were any queries.) Once the questionnaires were completed, coding frames were developed for the majority of the open ended questions and the data was analysed by SPSS PC. (Some of the responses to open questions did not lend themselves to this form of analysis, either because the responses were too complex to reduce into a coding frame, or there were too few to be able to do so.)

The profile of the questionnaire sample with detail on age and sex, social class, educational background, housing tenure and ethnicity of respondents of the questionnaire sample is shown in Tables 4:3 to 4.8 below.

**TABLE 4.3: AGE/SEX PROFILE OF QUESTIONNAIRE SAMPLE**

	FEMALES		MALES		TOTAL	
	%	(N)	%	(N)	%	(N)
<b>18-24.11</b>	19	(10)	15	(8)	17	(18)
<b>25-44.11</b>	48	(26)	48	(25)	48	(51)
<b>45-64.11</b>	22	(12)	25	(13)	24	(25)
<b>over 65</b>	11	(6)	12	(6)	11	(12)
<b>TOTAL</b>	100	(54)	100	(52)	100	(106)

[1 missing case]

**TABLE 4:4 OCCUPATIONAL STATUS OF QUESTIONNAIRE RESPONDENTS**  
 [Registrar General Classification]

	II		IIInm		IIIIm		IV		V		Not in Paid work*		TOTAL	
	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)
<b>FEMALES</b>	19	(10)	30	(16)	13	(7)	1	(1)	2	(2)	35	(18)	51	(54)
<b>MALES</b>	28	(14)	6	(3)	2	(1)	26	(14)	8	(5)	30	(15)	49	(53)
<b>TOTAL</b>	23	(24)	18	(19)	7	(8)	14	(15)	5	(7)	33	(33)	100	(107)

\*Not in Paid Work includes retirement (11%); full-time child/other care (6%); sickness benefit (5%); full-time study (4%); other/not stated (9%).

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**TABLE 4:5 Highest formal educational qualifications of questionnaire respondents**


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	NONE		GCSE/O/A		'PROF.'*		HIGHER ED		TOTAL	
	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)
FEMALES	26	(14)	46	(25)	11	(6)	17	(9)	100	(54)
MALES	48	(26)	13	(7)	13	(7)	26	(13)	100	(53)
TOTAL	36	(40)	30	(32)	12	(13)	21	(22)	100	(107)

\* 'PROF' includes further education, diplomas, nursing qualifications and anything between school and first degree.

\*\* HIGHER ED includes first degrees and above.



TABLE 4:6 Housing tenure of questionnaire respondents

	PRIVATE* RENT	L.A./** CO-OP	OWNER/ OCCUPY	SQUAT/ HOMELESS	PARENTS	TOTAL						
	%	(N)	%	(N)	%	(N)						
FEMALES	11	(6)	46	(25)	26	(14)	4	(2)	4	(2)	100	(49)
MALES	26	(14)	23	(12)	28	(15)	4	(2)	6	(3)	100	(46)
TOTAL	21	(20)	39	(37)	31	(29)	4	(4)	5	(5)	100	(95)

(12 missing cases)

\* includes furnished and unfurnished renting arrangements.

\*\* L.A. = Local Authority housing; Co-op = Housing co-operatives and housing associations.

**TABLE 4:7 HOUSEHOLD STATUS OF QUESTIONNAIRE SAMPLE**

	ALONE		PARTNER*		PARTNER/ CHILD(REN)		CHILD ONLY		PARENTS		OTHER		TOTAL	
	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)
<b>FEMALES</b>	17	(9)	35	(19)	15	(8)	5	(3)	4	(2)	24	(13)	100	(54)
<b>MALES</b>	25	(13)	28	(15)	34	(18)	2	(1)	5	(3)	9	(5)	100	(53)
<b>TOTAL</b>	20	(21)	32	(34)	24	(26)	6	(4)	4	(5)	16	(17)	100	(107)

\*includes spouse, cohabitant.

TABLE 4:8 ETHNIC BACKGROUND OF QUESTIONNAIRE RESPONDENTS

	ASIAN*	BLACK** BRITISH	IRISH ***	WHITE**** BRITISH	OTHER *****	TOTAL
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)
FEMALES	4 (2)	14 (8)	20 (11)	51 (27)	11 (6)	100 (54)
MALES	10 (5)	25 (12)	21 (10)	38 (18)	6 (3)	100 (48)
TOTAL	6 (7)	21 (22)	20 (21)	46 (48)	7 (9)	100 (104)

(3 missing cases)

The categories are refined from an open-ended question asking respondents to define for themselves their nationality and ethnic origins.

\* ASIAN [may be British or other nationality and includes ethnic origins from India, Pakistan, China.]

\*\* BLACK BRITISH [ includes African\Caribbean; Caribbean\Irish]

\*\*\* IRISH [persons defining themselves as such, mainly from Eire]

\*\*\*\* WHITE BRITISH [includes Scotland,Wales,England & N.Ireland]

\*\*\*\*\* OTHER [includes N. American, Italian, Cypriot, other European and Libyan]

Table 4.3 shows that about half the sample were aged between 25 and 45. The social class distribution overall was 41% 'middle' class and 59% 'working' class, with more women than men in social classes II and III non-manual and more men in III manual, IV and V. There were no significant class differences in ethnic background; the proportions were roughly the same in each classification for 'whites' and 'non-whites', although 'whites' of Southern Irish descent were more likely to be in the manual category (not shown in Table 4.3). Information on education was collected by asking at what age the respondents left school and whether they had any formal qualifications (see Table 4.5). Fifty-two percent of the sample (57% of women, 47% of men) had left school at age 16 or under and 48% (43% of women and 53% of men) were over 16 when they left school. 'School' had different connotations to some of those educated outside of the U.K. system, as some respondents indicated they had not left until the age of 21. Higher school leaving age and formal qualifications correlated significantly with higher occupational status. In this sample, although women are more likely to have school leaving qualifications, men are more likely to have achieved higher degrees. A third of the sample were owner-occupiers (Table 4.6). Twenty per cent of the sample lived alone, a third with a partner, and a quarter with a partner and one or more children (Table 4.7). As to ethnicity, 6% were Asian, 21% Black British, 20% Irish, and 46% White British (Table 4.8). The sample is representative of the adult population of this particular practice, but may show some local idiosyncrasies compared to larger surveys such as the General Household Survey (OPCS 1990).

### **The interviews**

The aim of the second stage of the fieldwork was to examine the themes of the questionnaire in greater depth, and to provide deeper insights into the complexity of pain

beliefs and perceptions by using a different, more subjective, approach which would enable definitions of pain to be broadened and more contextualised. In an earlier chapter, the psychologist Davitz (1967), is quoted as recommending that in order to understand emotion we should turn to great authors such as Dostoevsky, rather than social scientists. In a similar vein, attempts by medics to provide a taxonomy of pain reveal limitations of powers of expression:

‘To demonstrate their distress, most people readily offer dramatic affective language, describing pain in terms of tension, fear and autonomic distress. Expressions such as **exhausting**, **frightful** and **sickening** are often accompanied by paralinguistic vocalisations of moaning and groaning and non-verbal signs of affective discomfort to signal the sufferer’s distress to observers’ (Craig 1984:153).

This is not to suggest that subjective, qualitative approaches have **never** been utilised in pain research, as there is an expanding emphasis on the subjective nature of pain. The widespread use in pain clinics and hospices of the McGill Pain Questionnaire emphasises the importance of language and expression. It requires respondents to choose descriptions of the nature of their pain from lists of adjectives.

The vulnerability that pain gives rise to implies that it is a ‘sensitive’ research topic, a term which Lee and Renzetti (1990) point out is often thought to be self-explanatory, although it needs defining carefully. Topics are usually thought to be sensitive because they are controversial in some way, that is they may be threatening to either the researched or the researcher. Any participation in a research project involves the ‘costs’ of time and possibly inconvenience, but there may also be more unwelcome consequences such as guilt, embarrassment or even the possibility of discovery. The researcher may feel threatened by placing her/himself in compromising or dangerous situations, or by experiencing stigmatisation for studying particular topics. A prime consideration of the interview was therefore to conduct it in a manner which

acknowledged the potential vulnerability of the subjects in exposing their feelings about distressing experiences.

At the end of the questionnaire, respondents were asked to leave a name and address or phone number if they were willing to take part in any further research. Thirty-one respondents (sixteen women and fifteen men) volunteered initially, but when I made contact four people had moved from the address given and five were not willing to participate any more, despite agreeing initially. In two cases, I was unable to elicit the reasons for the reluctance to participate as the respondents either failed to turn up at the arranged meeting place or to answer the door. In each case, I made three attempts to arrange to meet without success. The reasons given by the other three were as follows; one man told me over the telephone that, being a black person, he was unhappy about talking to a white researcher, another refused to participate as he had assumed it would be a television interview, and one woman arranged a meeting at her workplace but later apologetically cancelled, as she said her husband did not wish her to take part. So eventually, eleven men and eleven women took part in the interview (see Table 4:9 for sample characteristics and Appendix 2 for brief descriptions of interviewees). The interview was arranged, usually in the respondent's home, although three people used their workplace and two came to the research unit as they did not wish me to visit their home.

In setting up the interview, the respondent was asked if he/she was willing to go into more detail about some of the issues in the questionnaires. As up to six months had elapsed since their completion, recall as to the contents of the questionnaire varied considerably, with some people having no memory of it whatsoever, whereas, for others, the subject appeared to hold great importance and the questionnaire responses were

**TABLE 4.9 CHARACTERISTICS OF INTERVIEW SAMPLE**

WOMEN	F1	F2	F3	F4	F5	F6	F7	F8	F9	F10	F11
AGE	33	29	67	38	37	18	47	36	56	34	28
OCCUPATION	Musician p.t.	Childcare f.t.	Ex-nurse retired	Secretary f.t.	Childcare f.t.	School	Charity fund-raiser f.t.	Social worker f.t.	Cleaner p.t.	Health worker f.t.	Shop assistant f.t.
ETHNICITY Nationality	White UK British	Nigerian English British	White UK British	White UK British	White UK British	Polish/Jewish British	White UK British	African/Irish British	White Irish	White UK British	White Irish
TENURE	Owner occupier	Council	Owner occupier	Council	Owner occupier	Parental home	Owner occupier	Private furnished	Council	Private furnished	Housing co-op
MOST PAIN	Brain tumour operation	3rd labour	RTA fractured skull	Peritonitis	Tooth abscess	Scalding	Back Injury	Death of mother	Nursing husband Alzheimers disease	Skin graft for leg operation	Back pain
MEN	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
AGE	28	23	38	25	66	50	35	36	40	62	27
OCCUPATION	Double glazing salesman f.t.	Freelance copywriter p.t.	Artist/ decorator p.t.	Actor p.t. Out of work	Dentist retired	Housing Admin. worker f.t.	Kitchen porter p.t.	Musician f.t.	Never worked due to heroin addiction	Ex-journalist Invalidity benefit	Scrap yard dealer f.t.
ETHNICITY Nationality	White Irish	Jewish/ German	White British	White British	White British	White British	White British	White British	White British	White S.African	White Irish
TENURE	Parental home	Parental home	Owner occupier	Squat	Owner occupier	Housing co-op	Council	Housing co-op	Council	Council	Council
MOST PAIN	Beaten by father as a child	Migraine	Infection of leg vein	Toothache/ panic attacks	Injection for tennis elbow	Toothache	Forcible ECT	Infected blister on hand	Kidney transplant	Leg amputation	Learning HIV positive

remembered accurately. The interview began by recalling the questionnaire and asking for more detail about the most painful experience the respondent could remember. In each case, this gave rise to a 'pain story', the length of which varied considerably.

In relating their experience, every person without exception talked about their feelings whilst recalling the relevant episode and/or incident(s).

The theme of physical versus emotional pain and the separation or interlinking of those two was universally explored, often without my prompting, although I did explicitly ask, if it had not already arisen, whether the interviewee thought that there was such a thing as 'emotional pain'. At this point in the interview, a sequence of visual images was introduced, aiming to explore further social perceptions and beliefs about pain. The final part of the interview centred around the questionnaire responses to gender differences and pain perception, and asked the respondent to explain the reasons for their particular responses. Other possible social factors were also probed if they had not yet been mentioned spontaneously - specifically ethnicity, class and age. Finally, interviewees were asked if there were any other factors which they considered were important.

The effects of research on participants has been an issue of importance in discussions of research practice, especially in feminist analyses (see Brannen et al 1991 for a review of the literature). Lee and Renzetti (1990:512) define four broad areas in which research is likely to be deemed threatening:

- 'a) Where research intrudes into a private sphere or delves into some deeply personal experience.
- b) Where the study is concerned with deviance and social control.
- c) Where it impinges on vested interests of powerful persons or the exercise of coercion or domination.
- d) Where it deals with things sacred to those being studied which they do not wish to be profaned.



Researching into perceptions of pain would seem to fall into the first category, but definitions of the 'private sphere' may vary considerably. Although by its very nature, pain may become a public concern, there can be little argument that it is a 'personal experience' which may be threatening because it is so emotionally charged. One possible reason for overcoming reluctance to discuss these socially 'taboo' topics is the desire for 'catharsis' - there may be gains in knowledge and other beneficial effects for participants.

Researching a sensitive topic raises many issues - methodological, technical, ethical, political, and legal. As a result, and as Lee and Renzetti (1990:513) point out, technical innovation can follow 'in the form of imaginative methodological advances'. The need to adopt an interpretative, phenomenological approach to pain beliefs led to the development of an innovatory use of visual imagery in the present study. As this approach appears to be somewhat unique, its development is described below in detail.

### **The visual imagery technique**

It has already been observed that the striving of technical scientific language towards neutral objectivity is discordant with the human ability to convey emotional and experiential qualities of pain. As a consequence, turning to the arts and literature is sometimes recommended as a strategy for better understanding the subjective nature of pain.

My own interest in using visual images in order to probe more deeply into beliefs and attitudes about illness and pain emerged initially from a 'lay' appreciation, especially of the relationship between art and society following the work of Berger (1969) and others challenging the exclusivity of 'high culture'. Despite the impact of sociological theories on art history throughout the 1970s and 80s (particularly Marxist and feminist critiques: see, for example, Fischer 1964; Nochlin 1971; Lippard 1976; Pollock 1982),

there have been few reciprocal attempts to enhance social perspectives. Within the social sciences, the study of perception has traditionally been embedded in scientific models, with a consequent lack of acknowledgement of the ways in which the social order is represented and endorsed by art. Wolff (1975), in her comprehensive account of a sociological perspective on art as a social product, speculates as to why phenomenologically-orientated sociologists have not turned to the arts, a seemingly logical progression, as:

'Like society, art is a creation of individual members who, in their turn, are in many ways, formed by society' (Wolff 1975:7).

She explores the methodological difficulties of developing a sociology of art, contending that the underpinnings of both positivism and phenomenology lack structural and historical perspectives. This gives rise to problems implementing the concept of a world-view to demonstrate that a work of art may express the ethos or ideology of a period or particular social group. Wolff suggests a hermeneutic approach to the analysis of imagery, involving the combination of two disparate epistemological enquiries, namely:

'the micro-analysis of the individual, phenomenological linguistic experience and the macro- or social knowledge-constitutive determining interests' (1975:36).

The flexibility and versatility of a sociological approach has already been emphasised in adapting to a framework of this nature, especially as an extension of the Vignette Technique described below. Imagery as a research tool in sociology appears to be under-utilised, and in general appears to be largely confined to facilitating psycho-analytic diagnoses, for example in the use of the Rorschach Tests. However, imagery has also been used in psychological research on pain perception in Pain Aperception Tests, the background to which is described below.

### **(a) Pain Aperception tests**

The Pain Aperception Test (PAT) was developed by Petrovich (1957) to measure pain reactivity. He tried to show that each individual is predisposed to perceive pain experienced by others in a characteristic and relatively constant manner, stemming from the individual's own experience of, and reactions to, pain. The test consists of 25 cards depicting a male in his middle thirties in various painful situations, divided into three main groups:

#### **1-9 Felt Sensations**

1. Man carrying tub of water from basement bumps head on porch.
2. Seated man cuts forearm while whittling.
3. Pedestrian is hit on shin by baseball.
4. Man seated on bed is clutching stomach with his right hand.
5. Man has shot himself in shoulder with rifle.
6. Kneeling man has been shocked while working on electrical outlet.
7. Man seated in lawn chair is drooped over with head supported by his right hand.
8. Swimmer injures toe on beach chair beside pool.
9. Man sprawled on hillside, left leg extended and twisted (broken) below knee.

#### **10-17 Anticipation vs. Felt Sensation**

10. Man falling from broken ladder in mid-air about two feet from landing on his back.
11. Same as 10 except man has just landed on his back.
12. Cake of ice dropped by ice-man is several inches from landing on his foot.
13. Same as 12 except ice has just hit his foot.
14. Man is about to receive hypodermic injection in deltoid.
15. Same as 14 but hypodermic is inserted in deltoid.
16. Man is seated in dentist's chair about to have tooth drilled.
17. Same as 16 except dental drill is in man's mouth.

#### **18-25 Self-Inflicted vs. Other-Inflicted**

18. Man hits thumb with hammer while driving nail.
19. Same as 14 except a second person wields hammer.
20. Man misses cup, pouring hot coffee on his left hand.
21. Same as 20 except another person (waiter) is pouring.
22. Seated man has pricked finger with needle.
23. Same as 16 except other person has pricked man's finger.
24. Man removing foreign matter from his eye with handkerchief.

25. Same as 17 except another person is holding handkerchief.  
(Petrovich 1957:343-4)

The respondents, 100 (presumably male) patients of the Veterans Administration Hospital at St Louis, Missouri, were asked to score the projected intensity and duration of pain on a seven-point scale for each situation by answering the following:

1. How does the man feel?

(Answers: no pain, hardly any pain, some pain, moderate amount of pain, much pain, very much pain, can't stand the pain)

2. How long will it hurt him?

(Answers: not at all, seconds, minutes, hours, days, weeks, months)

The study was unusual, in that the focus was on reaction rather than sensation, attempting to tap the emotional response to painful situations experienced by others. Petrovich claimed that high scores on the PAT correlated significantly with anxiety and neuroticism, using Taylor's Manifest Anxiety Scale (1953) and Eysenck's Personality Inventory (1956).

Despite the interest in the access to emotional responses that this test provided, the study proved difficult to replicate and was heavily criticised on these grounds. Identification with the sufferer in the test cards was thought to differ from subject to subject (the point that this may have been a gender issue as the subject was male is not raised). The criticism appears effectively to have curtailed any further development of the technique until Elton et al (1978) tried to replicate it in Melbourne twenty years later. They argued that the imagery material was considered too complex and ambiguous by the subjects and that the extraneous clues were too confusing. Subsequently, they developed a new measure which they named the Melbourne Pain Aperception Film

(MPAF) which depicted a bare hand and forearm in situations of increasing pain as follows:

1. Hand slapped.
2. Hand pinched.
3. Finger pricked with a pin.
4. Hand hit with a wooden ruler.
5. Thumb hit by a hammer.
6. Hand caught in a door.
7. Fingers burnt by a match.
8. Hot water spilled on a hand.
9. Hand cut deeply on the ball of thumb by a knife.
10. Fingers chopped off by an axe.

Elton and colleagues supported the view that the extraneous details in Petrovich's study were confusing. However, their own presentation of pain as 'disembodied' clearly implies a lack of respect for any broad cultural model of pain. The respondents in this study were men and women from three different groups: 'pain-prone' patients, 'organic' pain patients and a control group. They were given ten seconds between each segment of film to record their responses on seven-point scales. As with the Petrovich study, the analysis is limited, concentrating on significant correlations between variables, but not taking factors like gender into account. There were no significant differences found between any of the groups, and the authors concluded that although these types of test do not have much use as a clinical measure of pain reactivity,

'..they may be useful in determining intercultural differences in responsiveness to pain, and individual differences. When used in conjunction with other methods, they may tap some of the more elusive dimensions of pain' (Elton et al 1983:30).

This was precisely this quality that I was seeking for the kinds of questions I wanted to ask.

### **(b) The Vignette Technique**

Use of visual images in the context of a sociological interview has something in common with the vignette technique as used by Finch (1987) and others. She advocates the use of a hypothetical situation permitting the interviewee to define the meaning for him or herself and:

'... allowing for features of the content to be specified, so that the respondent is being invited to make normative statements about a set of social circumstances, rather than to express his or her "beliefs" or "values" in a vacuum... it acknowledges that meanings are social and that morality may well be socially specific' (Finch 1987:106).

The method developed in the U.S. in the late 1960's and used **factorial vignettes** used to mimic experiments. A basic story was presented which remained constant but the outcomes were varied, and responses recorded and analysed in survey fashion. The most common practice has been to follow the vignette with fixed responses. For instance, Lomas Cook (1979) used eight vignettes per interview to explore public support for welfare claimants, following these with a fixed set of five questions seeking the opinions of the respondents with yes/no responses.

In another study of the distribution of household income, Alves and Rossi (1978) included fifty vignettes per interview and followed each with a nine-point rating scale indicating approval/disapproval. Finch herself used a more complex form of vignette in her study of the public morality of obligations to assist kin. This involved the construction of characters in a story with up to three possible different outcomes. She stresses the flexibility of the technique:

'... asking concrete questions about third parties has the effect of distancing the issues.. this seems to make the questions less personally threatening, which may be very important when the sensitive features of relationships are being explored. It also has the effect of breaking away from the limitations imposed by the personal experience and circumstances' (Finch 1987:111).

Generally there seems to be a consensus that the use of vignettes is extremely valuable

in tapping general imagery, but does not foretell actions.

In the present study, a series of paired images were used (see Figure 4:1).

I already had a collection from various European art galleries of postcard reproductions of paintings and photographs with pain as a theme. Visits to the National Gallery, the Tate Gallery, the Photographer's Gallery, the Magnum exhibition at Haywards Gallery, the Museum of Mankind and the Natural History Museum expanded the collection up to 30 postcards, from which a workable selection was then made.

As the major focus of the study was gender, I was hoping to portray salient gendered images of pain (for example childbirth for women and battle for men). However, in my collection I was unable to find either a photographic or artistic image of a woman in pain in childbirth (the images I found depicted serenity, joy or even ecstasy). Nonetheless, the gendered pairs that emerged seemed to provide complementary contexts (see Figure 4.1 pairs 2,3 and 4). Other themes seemed to form natural pairs (pair 1 and 6) and some of these images also raised other issues such as age and race (pairs 2 and 5), which I wanted to include. Acknowledgment must be made of the subjectivity of the final choices, which are influenced by my own definitions and beliefs about pain, and by features of my own background, including my professional training in psychiatry. For instance, 'emotional pain' is a term open to many different interpretations, but I, personally, have no reservations in accepting it as a concept. That this is not the case universally is reflected in responses to the material. For example, the use of an image like 'The Lady of Shalott' to symbolise pain was quite mystifying for some people, both respondents and colleagues. Inclusion of that painting was clearly

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coloured by my own knowledge and interpretation of the story behind the painting.

Another complicating factor is that artistic material, particularly fine art, is highly culturally embedded. The collection of images I used is undoubtedly Euro-centric, and also covers varied timespans, which may serve to distract or influence any responses. The advantages and disadvantages of the technique are discussed in more detail together with the findings (see Chapter 6).

In the interview situation, respondents were presented with the 6 pairs of images, one at a time, without any information about the artist or the background (if desired, this was offered at the end of the sequence), and asked:

1. What is happening to the people in the picture?
2. Is anyone in the pictures in pain?
3. Is there more pain in one picture than the other?

Respondents were then shown all the images together and asked:

4. Who is in the most pain out of all the images?
5. Who do you identify with most?

Although there was no time limit, respondents were asked to give as immediate a response as possible, and were reassured that there was no right or wrong answer, and that I was not making any judgements about their responses, which were both noted and tape-recorded.

### **Data processing and analysis**

The whole interview, including the imagery sequence, was of an in-depth, informal and semi-structured nature, lasting on average for one hour for both men and women. However, some interviews were much longer, the longest being four hours. All the interviews were tape-recorded (unless the interviewee said s/he did not want this), and transcribed, and manual notes were also taken. For the analysis stage of the research, the word-processed transcripts were manually 'cut and pasted' into various themes. Due to

the size of the sub-sample, it was possible to assimilate all the material in an immediately accessible manner. For example, in the case of the imagery, the relevant quotes were pasted around each pair of images, forming a 'poster' which was then hung on the wall and studied. A similar technique was employed with the rest of the interview data, which was divided into themes. The main themes followed from the two major 'findings' of the questionnaire, summarised as follows:

1. Most people perceived women to have a superior capacity to men for coping with pain, or there to be no gender differences: a minority said that men were better at coping with pain. When asked why this was so, the female reproductive role was consistently used to explain this notion.
2. Analysis of the questionnaire data showed men were significantly less inclined to think the emotional component of pain perception had any importance.

The 'findings' are presented in the next five chapters. These begin with the findings of the questionnaire, and move through the analysis of the interview data and the responses to the visual imagery to the presentation of case studies. The case studies illustrate the way in which all three methods can be integrated to provide a comprehensive socially-located exploration of the meaning of pain.

## **CHAPTER 5.**

### **EXPERIENCES OF ILLNESS AND PAIN: SURVEY FINDINGS.**

This is the first of five chapters presenting and discussing the empirical data collected to explore hypotheses about the role of gender in the perception and experience of pain. In this chapter, results from the questionnaire survey are discussed. Chapter 6 considers those emerging from the in-depth interviews, and Chapter 7 discusses the use of visual imagery (Chapter 7). Chapter 8 explores the relationship between the different methods, and Chapter 9 presents detailed case-studies.

The purpose of the questionnaire survey was two-fold: (1) to provide information on gender and pain from a larger sample that could be included in an interview study; and (2) to generate questions which could then be explored in more depth using interviews and the visual imagery technique. Presentation of the survey findings below falls into two sections: **self-reported health and general health beliefs and experiences of, and beliefs about gender and, pain.** In comparisons between the findings of the doctoral research and other surveys such as the General Household Survey (GHS), the sample in this study will be referred to as the 'Kilburn sample'.

#### **Self-reported health\_and general health beliefs**

##### **(a) Health status**

Respondents were asked to rate their own health, both overall and over the last year: the answers are shown by gender in Table 5.1. According to Table 5.1, men are more likely than women to rate their health as excellent or as poor. The higher social classes are more likely to rate their health as excellent, and an increase in age correlates with an

increase in poorer health rating (not shown in Table 5.1). There are no obvious ethnic differences.

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**TABLE 5:1 Self-reported health status of Kilburn sample.**

	<b>Females</b>		<b>Males</b>		<b>All</b>	
	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>
<b>OVERALL HEALTH</b>						
Excellent	14	(7)	21	(11)	17	(8)
Reasonable	86	(46)	75	(39)	81	(85)
Poor	0	(0)	4	(2)	2	(2)
<b>Total</b>	100	(54)	100	(52)	100	(105)

**p= > 0.1**

---

(2 missing cases)

**OVER LAST 12 MONTHS**

Excellent	9	(5)	19	(10)	14	(15)
Reasonable	89	(48)	73	(38)	81	(86)
Poor	2	(1)	7	(4)	5	(5)
<b>Total</b>	100	(54)	100	(52)	100	(106)
<b>NS</b>						

---

(1 missing case)

These results can be compared to a similar survey of self-reported health measures of a random sample of 211 patients over 18 drawn from the records of a group practice (Blaxter 1985). Taking into account that the ratings of the two studies are different, in that the 'excellent' and 'poor' of the Kilburn study are more extreme than the categories used in Blaxter's study ('above average', 'average' and 'below average'), the same pattern of men being more likely to report good health emerges. Forty five per cent of men reported above average health, compared to 36% of women, whereas more

women (22%) reported 'below average' health than men (11%) in this sample. Non-manual men report their health as above average, whereas both men and women in manual categories are more likely to rate their health status as below average.

These social class differences fit with evidence about the relationship between lower socio-economic class and ill-health described earlier (see Chapter 1).

**(b) Long-term illness, disability or impediment**

Respondents were asked if they suffered from any long-standing illness, disability or infirmity, with the following qualifying explanation: 'for example, anything physical such as diabetes, arthritis, back pain; anything involving loss of functioning such as deafness, lameness, etc or anything emotional such as depression, anxiety etc'. They were also asked how long they had had the condition and how severely it affected their lives, whether they received any treatment and how satisfactory the treatment was. Table 5:2 shows that 50% of males in the Kilburn sample reported they suffered from a condition of this nature, compared to 33% of females. Responses to the question about whether their condition affected their daily life (see Appendix 1) were categorised as follows:

Not at all	↘		Quite a lot	↘	
A little	——	NON-LIMITING	A great deal	——	LIMITING
			Totally	↗	

and compared with similar findings from the 1990 General Household Survey (GHS). The GHS is an annual survey based on a sample (9623 households in the period from April 1990 to March 1991) of the general population resident in private households in Great Britain.

**TABLE 5:2 Reports of long-term illnesses: findings of Kilburn Sample and comparisons with GHS.**

	<b>Females</b>		<b>Males</b>		<b>All</b>	
	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>
<b>Kilburn Sample</b>						
All Long-Standing Conditions	33	(18)	50	(26)	41	(44)
Limiting Conditions	15	(8)	28	(15)	22	(23)
Non-limiting Conditions	20	(11)	19	(10)	20	(21)
Not reported	22	(17)	3	(2)	17	(19)
<b>Total</b>	<b>100</b>	<b>(54)</b>	<b>100</b>	<b>(53)</b>	<b>100</b>	<b>(107)</b>
<b>GHS 1990 Sample*</b>						
	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>
All Long-Standing Illness	35	(4258)	33	(3694)	34	(7943)
Limiting Illnesses	22	(2677)	19	(2127)	21	(4906)
Other	43	(5233)	48	(5375)	45	(10515)
<b>Total</b>	<b>100</b>	<b>(12168)</b>	<b>100</b>	<b>(11196)</b>	<b>100</b>	<b>(23364)</b>

\*Source: General Household Survey O.P.C.S. Monitor SS 91/1 G.S.S.p.11.

Table 5:2 shows that, in contrast with the national picture, the males in the Kilburn sample have an excess of morbidity over females. Three features of the sample are relevant here: firstly, the problem of smaller numbers; secondly, the fact that there were more men in the manual social class categories than women, thus increasing morbidity rates; and thirdly, the questionnaire was administered in the G.P. surgery waiting room, implying that respondents would be likely to be visiting their G.P. for treatment of a particular complaint. The most common complaint was chronic back pain, reported by 8 women and 5 men, other categories were very diverse with few numbers in each and covered: arthritis, diabetes, hypertension, loss of sight/hearing, psychiatric conditions and post-operative complications.

**(c) Last short-term illness**

As many respondents (19 men and 8 women) did not complete question 4, which asked about the last short-term illness (see Appendix 1), the responses are somewhat limited. As the questionnaire was administered in the waiting-room of the surgery, the responses covered a very wide range of complaints, which were condensed into 12 categories, as follows: influenza, upper respiratory infection, gastro-intestinal disorders, circulatory problems, skin conditions, gynaecological problems, asthma, migraine, accidents, psychiatric conditions, other infections, other conditions and 'none'. As the numbers in the cells were small, only the following conditions are reported, none of which show gender differences:



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**TABLE 5:3 Most common recent short-term illness/reason for attending G.P.: Kilburn sample.**

	<b>%</b>	<b>(N)</b>	<b>OF SAMPLE</b>
Influenza	31	(25)	
Upper Respiratory Infection	21	(17)	
Other Infection	10	(8)	
Gastro-Intestinal disorder	10	(8)	
Others	28	(22)	
<b>TOTAL</b>	<b>100</b>	<b>(80)</b>	

---

**(d) Health beliefs**

Open-ended questions asked respondents whether they thought there were aspects of their lifestyles which affected their health. Some examples were listed, and most of the respondents simply ticked or underlined factors they thought appropriate. Of the written responses, very few differed from the examples given, but some included broad topics such as religion, love, friends and happiness in the positive factors. The 'added-in' negative aspects were even fewer, but were more specific, such as genetic factors or emotional difficulties (for example, effects of bereavement, divorce, etc) which were not subsumed in the general 'stress' category. The factors that were thought to have the most positive or negative effects on health were as follows:

**TABLE 5:4 POSITIVE INFLUENCES OF LIFESTYLE ON HEALTH: KILBURN SAMPLE.**

	<b>Females [n=54] %</b>	<b>(N)</b>	<b>Males [n=53] %</b>	<b>(N)</b>	<b>Total [n=107] %</b>	<b>(N)</b>	
Good diet	67	(36)	55	(49)	58	(61)	<p.001
Regular exercise	44	(24)	51	(48)	48	(51)	<p.0001
Enough sleep	41	(22)	45	(24)	43	(46)	NS
Control over life	46	(25)	42	(22)	44	(47)	NS
Good relationships	46	(25)	40	(21)	43	(46)	NS
Regular holidays/leisure	37	(20)	32	(17)	35	(37)	NS
Job satisfaction	11	(6)	9	(9)	10	(11)	NS

Note: percentages do not add up to 100% as some respondents gave more than one answer.

The Blaxter (1985) study also asked respondents which factors out of the following were thought to have either a positive or negative effect on health: smoking/not smoking; abuse of alcohol/not drinking; illegal drugs; bad diet/proper diet; (lack of) exercise, fresh air; overeating, obesity/moderation in eating; anything in excess/moderation in all things; (lack of) sleep/rest. The most positive influences on health were thought to be exercise and fresh air (45%) and a proper diet (38%). Other factors were given less than 10% ratings as positive attributes. The factor thought to have the most negative effect on health was overwhelmingly that of smoking (61%), in contrast to the Kilburn study, the results of which are shown in Table 5.5; respondents in this sample gave higher ratings to overwork, boredom and stress. Other factors in the Blaxter study with more than 10% ratings were poor diet (21%), alcohol abuse (19%), overeating/obesity (14%), illegal drugs (10%), and lack of exercise/fresh air (10%), which differed substantially from the Kilburn sample.

---

**TABLE 5:5 Negative influences of lifestyle on health: Kilburn sample.**

	<b>Females [n=54]</b>		<b>Males [n=53]</b>		<b>Total [n=107]</b>		
	<b>%</b>	<b>(n)</b>	<b>%</b>	<b>(n)</b>	<b>%</b>	<b>(n)</b>	
Overwork	37	(20)	25	(13)	30	(33)	NS
Boredom	26	(14)	25	(13)	24	(27)	NS
Stress	30	(16)	21	(11)	24	(27)	NS
Smoking	17	(9)	26	(14)	22	(23)	NS
Poor Housing	20	(11)	19	(10)	20	(21)	NS
Fatigue	18	(10)	10	(5)	14	(15)	NS

---

Note: percentages do not add up to 100% as some respondents gave more than one answer.

Other factors mentioned in the precoded list used for the Kilburn sample did not receive substantial ratings (e.g. alcohol 8%; poor diet 6%; pain 3%).

## **Pain**

### **(a) Worst experience of pain**

One open-ended question asked respondents 'Could you describe the worst pain you've ever had, and what you think caused it?'. The question was asked in this way in order to explore what individuals would define as pain. The responses are classified in Table 5.6.

---

**TABLE 5:6 Most painful experience described by respondent: Kilburn sample.**

	<b>Females</b>		<b>Males</b>		<b>All</b>		
	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>	
<b>ACCIDENT/INJURY</b>	19	(10)	29	(15)	24	(25)	NS
<b>INFECTION/ILLNESS</b>	19	(10)	17	(9)	18	(19)	NS
<b>BACK PAIN</b>	9	(5)	17	(9)	14	(14)	NS
<b>CHILDBIRTH</b>	17	(9)	-	-	9	(9)	NS
<b>MIGRAINE</b>	8	(4)	6	(3)	7	(7)	NS
<b>SURGICAL</b>	8	(4)	5	(3)	6	(7)	NS
<b>EMOTIONAL/ PSYCHOLOGICAL</b>	5	(3)	2	(1)	4	(4)	NS
<b>OTHER</b>	6	(4)	15	(8)	11	(12)	NS
<b>NONE/NOT ANSWERED</b>	9	(5)	9	(5)	7	(10)	NS
<b>TOTAL</b>	100	(54)	100	(53)	100	(107)	

---

Gender differences are obvious in the experience of childbirth, but also in the larger numbers of men in the accident/injury category. the range of experiences was extensive, and difficult to reduce into categories. For examples, the accident/injury category included broken bones, burns, sprains, being shot in the ear with an air rifle, being run over by a car, being knocked off a bicycle, being beaten as a child, being mugged and having a

piece of grit embedded in the eye. Infections and illnesses included appendicitis, tonsillitis, pleurisy, gallstones, perforated ulcers, kidney infections, middle ear infections, colitis, mouth abscesses and an infected blister on the hand. The pains described as surgical were post-operative wounds, a skin graft and amputation of an arm and leg. 'Other' included toothache, trapped nerves, indigestion, cramp, menstrual pain and 'cold turkey' (withdrawal from heroin addiction). Only 4% (three women and one man) of the sample gave responses that did not involve physical pain; namely the death of a mother, the break-up of a marriage, having to leave the parental home, and being informed of HIV positive status.

#### **(b) Pain scales**

Pain scales have been consistently used to measure subjective responses (see Melzack 1975). In order to provide some comparative data, respondents were asked to rate how painful they thought an injection or blood test was on a scale of 1-6, and then to do the same with their most painful experience (see Fig 5:1). Although ratings for the worst pain ever experienced revealed few differences in the ratings of those who filled them in, women gave somewhat higher pain ratings to the blood test/injection score. This finding is consistent with the hypothesis that women are more likely to report less severe symptoms of morbidity (Verbrugge 1985). Alternatively, the pain associated with blood tests may be more salient for women because, as Popay (1989) points out, women are more likely to have experienced this type of health check more recently and more frequently, and men are more likely to 'divorce' themselves from the experience. Women who had experienced childbirth were also asked to rate that experience on the same scale.

p. 5:1

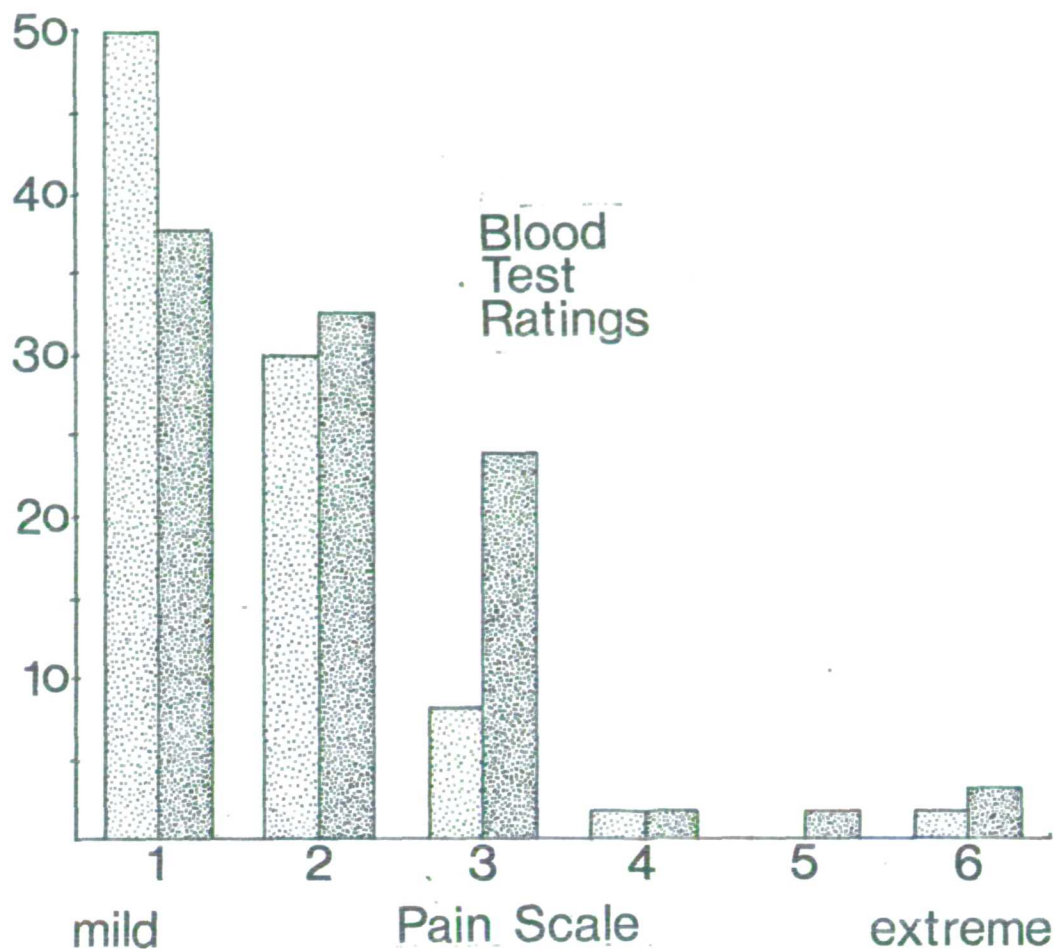
# PAIN SCALE RATINGS OF KILBURN SAMPLE RESPONDENTS

percentage  
respondents

(98)

47  
51

Missing  
cases

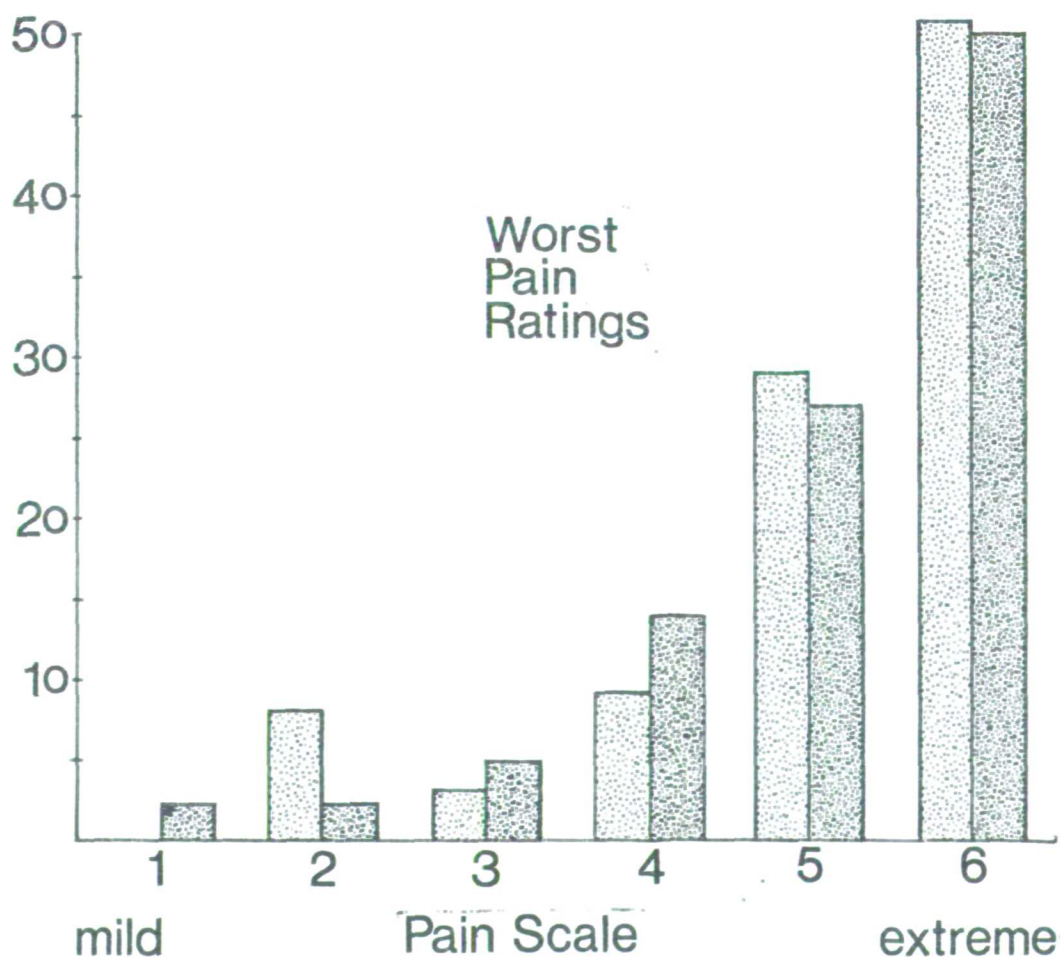


percentage  
respondents

(87)

41  
46

Missing  
cases



Of the 18 women who completed this question, the scores were as follows:

(Mild pain)	1	2	3	4	5	6	(Extreme pain)
(No. of Women)	10	1	3	3	0	3	

**(c) The role of emotions in perceptions of pain**

Table 5.7 shows that men were substantially less inclined than women to place importance on the emotional component of pain perception, certainly in terms of fear, anxiety and depression.

---

**TABLE 5:7 Perceived effects of emotion on pain: Kilburn sample.**

	<b>FEMALES</b>		<b>MALES</b>		<b>TOTAL</b>	
	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>
<b>ANXIETY</b>						
Little or no effect	37	(17)	60	(22)	47	(39)
Considerable effect	63	(30)	40	(15)	53	(45)
<b>TOTAL</b>	<b>100</b>	<b>(47)</b>	<b>100</b>	<b>(37)</b>	<b>100</b>	<b>(84)</b>
Missing		( 7)	(16)		(23)	
<b>P&lt;0.01</b>						
<b>DEPRESSION</b>						
Little or no effect	37	(15)	58	(21)	47	(36)
Considerable effect	63	(27)	42	(15)	53	(42)
<b>TOTAL</b>	<b>100</b>	<b>(42)</b>	<b>100</b>	<b>(36)</b>	<b>100</b>	<b>(36)</b>
Missing	(12)		(17)		(29)	
<b>P&lt;0.01</b>						
<b>FEAR</b>						
Little or no effect	34	(14)	46	(14)	39	(28)
Considerable effect	66	(29)	53	(16)	61	(45)
<b>TOTAL</b>	<b>100</b>	<b>(43)</b>	<b>100</b>	<b>(30)</b>	<b>100</b>	<b>(30)</b>
Missing	(11)		(23)		(34)	
<b>P&lt;0.1</b>						

---

This was a very difficult topic to raise in questionnaire format, reflected in the large numbers of missing cases. In the categories of anxiety and fear, twice as many men as women did not respond, despite completing the rest of the questionnaire.

**(d) Coping with pain: social expectations of men and women**

With regard to coping, questions were asked about both behaviour and attitudes. There were no discernible gender differences in coping behaviour: 30% of men and 36% of women sought treatment for their last short term illness, either by self-medication or seeing their G.P. 12 women and 15 men, 28% of the sample reported being in pain at the time of the questionnaire. Of these 27 people, 23 sought treatment from their G.P., 2 from an osteopath, 1 from a physiotherapist and 1 obtained medication from the chemist.

The question asked in the survey about gender-differentiated perceptions of pain coping attempted to be more neutral than the market research described in the last chapter (Nurofen 1990). It asked if respondents thought there were any differences in the capacities of men and women to cope with pain.

---

**TABLE 5.8: COPING WITH PAIN: KILBURN SAMPLE.**

	<b>FEMALES</b>		<b>MALES</b>		<b>TOTAL</b>	
	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>	<b>%</b>	<b>(N)</b>
Women cope more	66	(34)	33	(16)	50	(50)
Men cope more	8	(4)	17	(8)	12	(13)
No difference	25	(13)	42	(20)	33	(33)
Don't know	1	(1)	8	(4)	5	(5)
<b>TOTAL</b>	<b>100</b>	<b>(52)</b>	<b>100</b>	<b>(48)</b>	<b>100</b>	<b>(100)</b>
<b>Missing</b>	<b>(2)</b>		<b>(5)</b>		<b>(7)</b>	

**P<0.0001**



Although the results did not show the same extent of ascribing higher expectations of women as the Nurofen (1990) market research, the men in the Kilburn sample were still more likely to say there were no differences between men and women, with only a minority of both sexes weighted towards men coping better.

The survey data also included some open-ended material on the reasons given for these opinions filled in by some respondents. As these data relate to explanations of one of the significant gender differences found in the survey as a whole, it seemed appropriate to apply the analytical framework described in Chapter 2 used to explain gender differences in morbidity. Responses were categorised into themes which were biological, or used theories of socialisation or social roles: see Figure 5.1. However, as Figures 5:2 and 5:3 show, these categories proved too simplistic for some replies, which encompassed more than one theme.

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**FIGURE 5:2 Open-ended Survey Responses Explaining Why Respondent Chose Category of Pain 'Coping' Behaviour.**

**A. RESPONSES USING 'BIOLOGICAL' EXPLANATIONS OF MEN'S AND WOMEN'S PAIN 'COPING' BEHAVIOUR.**

**'WOMEN COPE BETTER' 50% of Total Sample**

**FEMALES** 'It's a sexual difference, women are built that way '  
'Women go through things like childbirth'

**MALES** 'Childbirth'  
'Because I have seen the pain my wife has been through in childbirth..'  
'Men and women are made of the same 'stuff'- other than reproduction.'  
'It's physiological'

**'MEN COPE BETTER' 12% of Total sample.**

**FEMALES** 'Men are stronger'  
'Because of physical ability'

**MALES** 'Men are stronger'  
'Physical differences'

**'NO DIFFERENCES' 33% of Total Sample.**

**FEMALES** 'We all have the same central nervous system'

**MALES** 'They are both human'  
'Because pain is pain'  
'After all we are the same'

**B. RESPONSES USING 'ROLE' EXPLANATIONS OF MEN'S AND WOMEN'S PAIN COPING BEHAVIOUR.**

**'WOMEN COPE BETTER' 50% of Total Sample**

**FEMALES** 'Full-time routine to carry out'  
'Women usually just have to get on with it because of kids and homes or jobs to keep'  
'It's more a state of mind'  
'It depends on an individual's character or attitudes, not whether they are male or female.'

### **C. RESPONSES USING 'SOCIALISATION' EXPLANATIONS OF MEN'S AND WOMEN'S PAIN COPING BEHAVIOUR.**

#### **'WOMEN COPE BETTER' 50% of total sample**

- FEMALES**
- 'Men are more childish'
  - 'Because of societal conditioning and necessity'
  - 'Women are conditioned to cope with more pain'
  - 'Men can be big babies'
  - 'Men show more feelings of pain, women control them.'
  - 'Men just don't like pain'
  - 'Women have to cope, no choice'
  - 'Men are just like little boys'
  - 'Men are just babies'
- MALES**
- 'The average man always thinks he's tougher than he is but is not so good at coping with pain when it happens.'

#### **'MEN COPE BETTER' 12% of total sample**

- FEMALES**
- 'Men do not show pain as much and therefore are able to cope with it whereas women express pain more.'
- MALES**
- 'Men are more relaxed, less anxious'
  - 'Men have more determination, so can put things off.'

#### **'NO DIFFERENCES' 33% of total sample**

- FEMALES**
- 'There's a popular myth of men as bad patients- it's not true except that in it may affect behaviour and expectations of behaviour but it seems unlikely to be sex-defined.'
  - 'It depends upon the person, it's not sex-determined.'
  - 'It depends on the individual and how much patience they have'
- MALES**
- 'People harden themselves against pain. Throughout our lives we undergo painful events.'
  - 'It's more a state of mind'
  - 'It depends on an individual's character or attitudes, not whether they are male or female.'
-

---

**FIGURE 5:3 Responses Using 'Dual Explanations' of Men's and Women's Pain 'Coping' Behaviour.**

**A. BIOLOGICAL/SOCIALISATION EXPLANATIONS**

**'WOMEN COPE BETTER' 50% of Total Sample.**

**FEMALES**

'Women get more used to pain because of dysmenorrhoea etc.'

'Women are stronger emotionally'

'Due to the menstrual cycle and child labour they are more prepared for pain and their tolerance is highest.'

'Mentally women are stronger and have to cope with regular physical pain and are therefore more used to it.'

'I just think women can endure a lot more than men generally, both emotionally and physically.'

**MALES**

'Women have more strength, they don't moan so much.'

'Often women experience frequent pain and learn to deal with it.'

**'NO DIFFERENCES' 12% of Total Sample**

**FEMALES**

'It depends on the pain threshold of the individual.'

**B. SOCIALISATION/ROLES**

**'WOMEN COPE BETTER' 50% of Total Sample**

**FEMALES**

'Men give in to pain easier, but women (especially mothers) soldier on, they have no choice as children need caring for.'

'Women usually have to care for others and are not able to take to their beds as easily as men.'

**MALES**

'It's a well-known fact that men - and I'm one - can't stand pain. Women take things in their stride.'

**'NO DIFFERENCES' 12% of Total Sample**

**FEMALES**

'It's more a question of how they express it, how they deal with it, there's a difference in the social acceptability of expressing pain.'

**MALES**

'I feel that there are determining factors other than what sex the person is.'

---

The more complex and longer the responses were, the more difficult it was to 'fit' them into the categories, so that the more sophisticated explanations that people gave to explain why they thought women are able to cope better with pain can be seen to embrace all of the hypotheses:

---

#### **FIGURE 5:4 Multiple Explanations of Men's and Women's Pain 'Coping' Behaviour.**

##### **'WOMEN COPE BETTER' 50% of total sample**

##### **FEMALES**

'Women are made to suffer pain through periods and childbirth. Whatever social climate, women end up child-rearing, therefore they don't have the privilege of giving in to pain and sickness.'

'Nature has built women that way to cope with everyday pressures - raising a family, running a home, etc.'

'Because there are more illnesses and problems that women have to face - all throughout her life a woman is different.'

'Women give birth. Most women just have to get on with it whereas men can be mothered.'

##### **MALES**

'Women have more physical awareness - a more intimate and responsible instinct to their biology - all we do is shave.'

'Pain affects different people in different ways. Men feel they have to cover up pain as it is supposedly a sign of weakness.'

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#### **Conclusion**

The data from the questionnaire survey presented in this chapter can be summarized as revealing the following differences between men and women in perceptions and beliefs regarding pain:

1. Men were significantly less inclined than women to think the emotional component of pain perception had any importance.
2. Most people perceived women to have a superior capacity to men for coping with pain, or there to be no gender differences: a minority said that men were better

at coping with pain. When asked to expand upon why respondents made their choices, the reasons given involved theories of socialisation and roles as well as biological explanations.

The fact that the longer the written responses to this question were, the more complex was the explanation, suggested that alternative research methods might enable the subject to be explored in more depth. The next stage of the research design attempted to explore these phenomena in the context of an in-depth interview.

## CHAPTER 6

### THE CONCEPTUALISATION OF PAIN: INTERVIEW FINDINGS.

'I think you can experience pain on a spiritual level, a mental spiritual level - on a physical level and an emotional level. And although they are holistically one, I would separate them. So if I was a doctor and somebody was suffering from mental pain which was then coming out of the body through things like arthritis or who knows- then that would need a course of treatment and I would say "Oh you're in pain, take this tablet" but if its spiritual anguish it would need another treatment, emotional the same thing - you'd need love. We all need love, we all need care, we all need everything...' (Daniel, respondent M8 in interview sub-sample).

In this chapter, extensive quotations are used from the interview respondents and pseudonyms are used in order to protect their confidentiality. The main aims of the interview, as outlined in Chapter 4, were to provide an approach which would provide in-depth interpretive and subjective accounts of the research questions highlighted by the responses to the questionnaire. This chapter presents the main findings of the interviews relevant to the central research questions of the thesis.

The first research issue is raised by exploring the role of emotions in the definitions and experiences of pain. It was hypothesised earlier that the Cartesian 'split' between mind and body poses difficulties for conceptualising pain, as the primary emphasis is on the **nociceptive** or sensory qualities. Although most people in the questionnaire survey defined their worst experience of pain in largely physical terms, emotions were seen to play a part in the process, a gendered notion weighted towards females. By analysing the accounts of experiences of the most painful events of their lives, this chapter explores how the respondents define, and subsequently build up, belief systems about pain. Chapter 7 aims to provide a similar analysis of responses to the imagery.

## Pain stories

An important aim of using in-depth interviews was to try to 'deconstruct' the mind/body dualism which permeates more clinical approaches to the assessment of pain. In the interview, respondents were asked to describe the most painful experiences of their lives. The following quotes from these 'pain stories' provide vivid illustrations of the complexities involved in talking about pain. In relating their own experiences, subjects discussed pain in not only emotional as well as physical terms, but included spiritual, philosophical and existential notions. Looking at the taxonomy, the terms mental, emotional and psychological were used repeatedly and interchangeably as the following examples show:

'Pain itself - it's quite hard to remember **physical** pain - I think probably **mental** pain is the worst - it's hard to say and I can't remember what I put down but I think **mental** pain is worse than **physical** - the **physical** is hard to remember, it goes but the **mental** stays there.' M1

'No, it isn't just a **physical** thing - it's the way you think about what happens - of course it's **psychological** in that respect and how you think it's going to affect you or not. I mean the worst pain I've witnessed is with my wife having the children and that's something which is a much longer term thing happening, sort of 24 hours on the go. I mean something like what happened to me - a blood infection in the leg - you can put it outside yourself basically in a way, chop it off... but not in the case of having a child - it's something you have to see through to the end. In the case of bereavement the time span is longer so the shock wears off and pain gets much longer and larger in that case - so I suppose that's the most fundamental case [of emotional pain] I can think of. Though there's also **emotional** pain in the things you bring up in yourself and discover about yourself and the angst you have, so there's a lot of **emotional** stress in that sense.' M3

'You see I've not suffered **physically** that much - I don't know if I'd even say I'd suffered **emotionally** - I mean life is incredibly painful, it's perverse in a way. I know I put that the worst pain I'd experienced would be an **emotional** pain which for me is as valid as other types of pain - I always feel that **physical** pain gets all the attention. I'm not saying the two aren't related but for me I think the most painful experience if you qualify pain, **emotional** or **physical** was when my mother died and I'm still not over that. I don't think you can articulate pain, I don't think you can find words for



**physical** more than **emotional** pain, I can't find the words... ache? I think doctors should do more work on their language, like what's been done for children like "I've got a headache in my tummy type thing". I think it's very very hard to find words to express that pain and it's also hard knowing who to express it to.' F8

Everyone in the interview sample acknowledged or made reference to the existence of 'emotional pain' as a concept, with many respondents expressing the view that it had the potential to be equal to, or worse than, physical pain:

'I don't know, in some ways it might be easier to be in **physical** pain than **mental** pain, especially like with people with schizophrenia, they're often described as being in **mental** pain, aren't they but usually it's a **physical** thing, there's more chance that the doctor or someone can cure...' M6

'.. it's very **psychological** pain - if you don't think about it and take your mind off it, it will go away or it's not as bad. So if I burn myself now, I just sort of run it under a tap or read a book or go out, or ring up someone, I don't think about it.. **emotional** pain is something that I've felt quite a lot - in a way I think it's worse than **physical** pain - that's tangible and you know what's causing it and you can put your finger on it - well it hurts there, that's the reason but **emotional** pain - I mean I don't think anyone can explain why human beings have emotions. But because people are capable of loving a great deal, hating a great deal - if someone you love does something nasty out of spite well that can be worse than any **physical** pain.' F6

The responses indicate that there may be a level of stigma, in the form of increased personal vulnerability attached to revealing emotional or psychological pain, and that this appears to be the case for men more than women. Pain with an easily demonstrable pathological cause, superficially at least, would seem to have more respectability and authenticity:

'Of course there is **mental** pain as well but only in its **true** sense pain is **physical** - I mean they're not the same thing - I mean there's **mental** pain and there's **physical** pain but they're not the same thing - I mean the pain that I've known has been purely **physical** sort of things. I mean the other sort of pain comes through problems but it's not related to the **physical** part. I suppose the few times I've been in jail I would say it's painful but not **physically** so....' M7

'**Emotional pain, emotional pain**, I'm sure I've experienced it but I don't know how to put it into semantics really. It's not the same as the type of pain in my hand In that period I could go to sleep without pain in my mind and wake up - it'd be the first thing I'd register when I woke up, you know what I mean, that's how serious the pain was whereas **emotional pain** - I can't put my finger on what it is but maybe it's a disturbance - a disturbance of the mind which causes you to feel depressed for no reason or full of anxiety for no reason, or incapable or impotent or all those things, for no apparent reason, maybe that's pain. But to me, I've experienced those things but I don't let them get to me... the actual term exists doesn't it so I don't want to fight against the fact that people can be in **emotional** hurt. You know "Are you hurt by this situation - yes I'm very hurt" but then how do you measure that against other hurts.' M8

'Maybe **physical** pain has more legitimation. Now that I'm trying to measure or find the words for **emotional** pain, I'm not saying it's not to be taken seriously because people get psychosomatic pains from depression like headaches, real aches. I don't get any of those things, I don't think I do. But then maybe the headache I had last month was an **emotional** pain! M5

'I don't think of what I'm suffering as cancer pain though, I think of it entirely as pain resulting from the operations. I don't even acknowledge that there is such a thing as cancer pain - I just think there's pain and that the pain - it wasn't pain exactly in the same way - there was a feeling of illness and physical debilitation and breakdown before I went to the medics but that was quite different from the sharp **physical** pain that I have felt which I feel is due to the severing of the nerves in the operation which is how I crudely understand it...'

'I do know quite a lot about depression and **emotional** distress and I wonder if we have a universal vocabulary of measurement to deal with this but I did read somewhere that **physical** pain is a means of solving your other problems. **Physical** pain drowns problems of depression and whatever because it's so immediate and so intense..' M10

The women in the sample were equally likely to make the same emotional/physical distinctions, but provided more holistic overviews, and were more able to acknowledge their emotional vulnerabilities:

'I think you can see **physical** pain as a result of **emotional** trauma... like you asked how you see things in your life affecting your health and one thing I put was things going well within the primary relationship and - I've recently split up from my partner in the last few weeks and I know that some of the **emotional** pain I've had from that has been experienced **physically** in terms of um - really aching inside all around the stomach and

- I'm sure that's an **emotional** thing but I can feel it **physically**... I think that - it may be different for different people but I know that **emotional** pain and stress manifest themselves in **physical** ways in me and I can recognise my stress responses and I do get sort of aching inside and I come out in cold sores. On one occasion I came out in an incredible itchy rash and as soon as you start dealing with the stress that's provoking that, then it stops. There's probably something in between that, it's a two-step thing... but the **emotional** pain goes on longer - I think it's somehow worse than a **physical** pain because that is usually comprehensible, logical and there's a certain amount of control- you can get your head round it but I'd rather go through half an hour of what I described happened to me in hospital than two months of what I've just been through...' F10

'Emotions are definitely crucial to **physical** sensations of pain - when I can step back from what's going on and detach myself- when I can recognise that I'm more than this body that's going through its process in its own way. The body has a strong self righting mechanism that when I can detach from it, I can let it work itself out, it can balance itself. I don't need to take pain-killers but then also if you are in extreme pain and you don't have a strong enough sense of your own being as apart from your body then it can just compound it. I have become interested in consciousness through this and I practice meditation - I think that an awareness is essential, not only for the health of the body but of the mind and the **emotions**.' F5

'I find with other women we can express our pain easily, um I don't find that freedom with the medical professions - I feel as if I have to prove it without a doubt.. ' F8

The relative informality and personal contact of the interview appeared to broaden the consideration of experiences which could be defined as pain. Some respondents completely changed their classification of worst pain from questionnaire to interview, from something physical to an emotional or psychological condition. For instance, Tim (M4) had indicated that his worst experience of pain had been of a toothache, which had lasted several days, but as the interview progressed, it emerged that he was experiencing something that was ultimately much more distressing, as the following account shows:

'I have been experiencing, what has been described as panic attacks but I don't know if it's a really suitable description, the first time it was like a depersonalisation and once that occurred, for the next four or five days,

whatever I did when I picked up a cup or looked in the mirror, I felt totally separate from whatever was going on - it was like an inner terror... its gone and its come back and I've been seeing a psychologist for seven months and I'm going to have acupuncture. It always comes at completely illogical times, it's not as if I'm a depressive - I don't have a recurrent theme in my head. It can come when I'm feeling incredibly happy and relaxed, that's what's so frustrating about it... because the whole time I've been convinced it's something physical, obviously, because it makes it that much easier to bear, and more respectable somehow - I mean I still think maybe I've got a chemical imbalance or I ought to try maybe more homeopathic things, I don't know that much about it but it just seems like sitting in a room with some bloke talking about my childhood doesn't bear any kind of relation to the kind of feelings I'm going through. And I mean it is like a physical pain at times, it's like a vice on my temples and an incredible pressure on my head that it does produce a headache but essentially it's just a brooding feeling within the skull. That's why, I mean I've been to see doctors and G.P.s and I really wanted to have a brain scan and all these things. The longer its gone on the more I've sort of come to terms with it - I always carry diazepam, its like a safety measure - I very rarely use it but it's nice to know it's there.' M4

He had not felt that these experiences were legitimately included under the umbrella of 'pain', as demonstrated by his insistence on trying to establish a physical cause for his complaint.

Similarly, as the interview with Jane (F7) progressed, she became increasingly confiding. In the questionnaire she had, almost apologetically, claimed to have had an uneventful life, her most painful experience being a back injury as a teenager, from which she quickly recovered. But as the interview progressed, another story emerged:

'Oh there's certainly emotional pain, without a doubt and I think I've experienced that over my son over a long, long time and which I have only in the last couple of years come out of he's 21 now but I wouldn't have talked about this in the questionnaire.. there may have been damage from when he was born, although nobody's found evidence of that, either he was born with it in his personality or something went wrong but he's quite a troubled young man he was a very troubled child but I wouldn't say he was - he's not in the mainstream now but it may be that he's just a maverick person and may never be in the mainstream but he has a lot of charm and he's quite entertaining. Now I don't worry about him. I think what caused a lot of the pain was the worry about him and if I'm honest, the worry of what other people would think about me because of his behaviour and I think there is an element of that in all parenting and it

took me a long time to stand up to authority - to say, well that's the way he is, you know and not to worry, to shed some of the responsibility - I don't feel answerable.. it has certainly been worse than any physical experience but then apart from hurting my back, I've been a very healthy person, I don't have ongoing pain in any way so - but my God I did have a lot of emotional pain and that went on for a very long time - in fact I ended up having psychotherapy myself for 4 years when he had psychoanalysis.' F7

Pain was not, in general, necessarily viewed as entirely negative; it ranged from being seen as a sign of health, a warning to the body as in acute, usually physical pain:

'I don't think pain is necessarily negative - it's the body telling you something, at least with acute pain.. I mean I'd be very upset if I didn't have any nerve endings. And I mean you do come across people who don't have that facility and it's very upsetting because they can't walk around, they have to walk around in a so-to-speak bubble.' M2

'No, I think people grow from pain. Thinking of mental pain, I mean grief - that can make you - it's not nice to feel it obviously - but it can make you a stronger person, a more aware person, of the things that are going on around you. Like watching whales being slaughtered - that isn't a nice thing to see but if people don't see it then they won't believe they do feel pain and they won't do anything about it so I think pain can be ..it depends what sort, like physical pain - if you touch something hot, then yes that teaches you not to do it again but if you get pain like rheumatism, that sort of long-lasting, nothing - you - can - do - about - pain, that isn't good - no-one can learn anything from that. So sort of short-term it is useful, it can teach you- it is healthy to feel pain because it means you've got all your senses in working order so you don't damage yourself.' F6

Pain can even be described as 'productive'. This was often the case with childbirth, at least that resulted in live birth. In fact, only one of the women in the sub-sample had rated childbirth as her most painful experience (Suni F3). However, Suni had already given birth to two other children, but her third labour had resulted in a lengthy Caesarean, and she felt that the increased pain was associated in everything going 'wrong'.

Elaine explains why she considered an ear abscess to be far more painful than any of her four labours:

'I think that any woman who's had a baby isn't going to exaggerate - you've got a much better understanding I think of whether things really do hurt or not. So I had this abscess and I thought that was much worse than labour because that was sort of sheer undiluted pain whereas in labour the pain is sort of mixed in with all sorts of other feelings - I think that the feeling of this other person inside you wanting to get out is stronger than just sheer sort of pain that makes you want to bang your head against a brick wall, which is what I thought the abscess was like and I couldn't eat or sleep or talk, I couldn't get away from it at all and I'm not very good at bearing that kind of pain, I suppose because I thought there's no point to it either. Where with childbirth - I'm not one of these people who says it doesn't hurt, maybe for some people it doesn't but it does for me..but it's different, it's not sort of pointless pain that sends you out of your mind, partly because it comes in waves anyway and it's only for a short time altogether and then I think this sort of feeling of the baby trying to get out is stronger... I've had the fourth baby now and I haven't changed my mind.'

**F4**

The issue of control is central. Pain becomes increasingly negative the more uncontrollable it becomes. It is also more likely to be viewed negatively when chronic and/or terminal:

'Pain is only negative if it doesn't go away - it's positive in that it alerts you that something's wrong, you have to take things easier or whatever.. but it's when it's caused by some insidious disease you can't cure-then it's a real pain! **M6**

When the pain is unable to be controlled, it appears to be more threatening:

'I don't know because I think it goes hand in hand with the mental frustration as well, depending on here it is - with the toothache I think I got the point where I was in a state of panic, that feeling of desperation because it was so persistent, mentally it's a larger ordeal than just the toothache itself. Also the more it didn't get sorted out - I just got to the stage where I wanted to say to pull out the tooth, that was the only way I could see any release.' **M4**

'It depends, when you're angry and you hit someone or hit something to get rid of your anger then you don't initially feel the pain, it's only afterwards when you're more relaxed and calm you feel what you've actually done. Because I know that once, a long time ago I had a complete temper tantrum and I just stormed out of the house and out into the back garden and bashed my hand against the wall and I didn't actually feel it till I came in and it was all grazed and bloody and then it started to hurt - but at the time I think my emotion of anger overcame the pain, so it's - also when you're upset pain is more painful-when you're like tearful anyway or

sort of depressed- it's a lot to do with attitude - if you're in a very good mood and you hurt yourself you tend to laugh it off..' F6

The location of pain in the body may be important. Helena (F5) felt that the emotional pain of the removal of her ovaries, and the subsequent implications of childlessness, exacerbated and was worse to bear than any physical suffering she endured. Tim (M4) described how humiliated he felt by the removal of varicose veins from his testicles a few weeks before his wedding, which again far outweighed the physical hurt. Pain in the region of the head was thought to be particularly hard to endure :

'I think if you've got a bad foot or if you've got a pain in wherever else in your body it's still possible to go about your daily business if you have to. But if you've got a headache or migraine or something like that it tends to throw you so completely you're not able to cope with everyday things because its like a battering..' M11

'I think some parts of your body are more amenable to that so you can put up with them more whereas pain anywhere to do with your head is impossible to get away from. Apart from taking strong pain-killers which I don't think even work you can't make it better.' M2

Chronic and/or terminal pain is linked with depression, poor self-esteem and mental illness. Again, the issue of control is central here, and can be linked to a sense of powerlessness. Explanations sought for such pain often involve self-blame. For instance, Peter repeatedly mentioned that he thought he had neglected his health in the past and felt that it was seen to be an important factor in the development of his malignant tumours, especially by health professionals:

'One thing that worried me about the Bristol approach [to cancer] was that deliberately or accidentally it seemed to encourage the attitude that patients were in some way responsible for their illness, that they had brought it upon themselves. I've been thinking about that a lot and I do acknowledge that in the past I have neglected my own health and been casual about it but to say that I had wanted in some strange way to be ill seems iffy. I think there are many factors involved. There is the economic factor - I've been unemployed on and off for a long time. There's the question of ignorance - having come from a privileged background where

I never had to cook I'm bad at cooking for myself.... there are enough problems in coping with the pain without worrying about the stigma.' M10

Helen had a strong sense of self-blame and failure, which she expressed in almost punitive terms, resulting from the disabilities incurred from a hit-and-run accident:

'Before my accident I was a carefree, very with - it, I could always.. sort of think what the day was and what I was going to do this time next week, on Tuesday I must get my order ready for my groceries and what-not. Now, I don't know from one day to the other what the day is and what I've got to do - I look think oh it's 2 o'clock and I've made no lunch and things like that - I've lost all my preciseness- it's all gone by the board, I'm just an old, an old has-been now I feel.' F2

Beliefs of **punishment** were expressed by other respondents who had experienced traumatic events in their lives. Marie (F9) felt that the burden of caring for her husband with Alzheimer's Syndrome, in nightmare conditions, was ordained by God and used her Catholic faith both to explain and sustain her predicament. Sean (M1), on the other hand, had developed a complex belief system around religion and race, to explain his misfortunes. He was aware that his views were subject to much disapproval within his circle of family and friends. Nevertheless he felt very strongly that all his problems, both medical and emotional, and the resultant pain he had to endure, resulted from his being

'a cross-breed, I don't mean in terms of colour but I'm meant to be Irish but I'm not really pure.. it's all to do with the Jews. My mum's real mother died when my mum was only 17, she was Jewish ... I think it's a curse that follows people around and now I think it's following me and I blame a lot of the problems that I have...' M1

A crucial factor expressed by all the respondents in the ability to stay in control and subsequently cope with pain, was the amount of knowledge and information about what was happening to them. Patrick (M11) broke down and cried as he described how he was told of his HIV positive status, as he felt that the doctor had such contempt for him, he was unable to ask for any information or support. Peter (M10) related how humiliated he felt when an examining doctor commented on his low pain threshold due



to Peter's flinching away from an unexpectedly painful probe. Treatment by health professionals was a major issue:

'It's definitely more complicated than just a physical sensation - in my experience the whole thing of having my leg smashed up and surgery five or six times, being in intensive care and all that - the times when I was getting information about what was happening, the times when I wasn't afraid I was being kept in the dark about it, the times when I felt supported, were the times when you know I could deal with the pain much better and it was the times when I didn't feel like I had that support and I didn't feel that people were honest with me that I found it much harder to handle...' F10

## Conclusion

The location and nature of these interviews as a context for the expression of experiences and beliefs about pain differed from those of the questionnaire survey. The interviews took place outside the clinical environment of the G.P.'s surgery, and were more intimate and informal than the questionnaire completion. These differences may account in part for the intensely personal accounts of pain that emerged.

Several major themes have emerged. Although the way people conceptualise pain appears to transcend the dualistic mechanistic assumptions inherent in Western medicine - pain is seen to have emotional and existential, as well as physical, aspects - there appears to be a belief that there are hierarchies of pain, in the sense that some forms of pain are more socially acceptable than others. Obviously this may vary by social group or by culture, and it is not possible to make sweeping generalisations from a sample of this size. Nonetheless, pain with a pathological, usually physical, cause appears to have more respectability, validity and authenticity and is more of an issue, for men than for women. The women in the sample were more likely to acknowledge their emotional vulnerability, and to emphasise its impact on their ability to feel or not feel pain.

The Hippocratic assumption that pain always needs to be alleviated or relieved

was refuted by many of the respondents with the theme that there are both positive and negative aspects of pain. If pain is acute, it can be seen as a sign of health, both physically and emotionally, in the sense of providing a signal function to both mind and body. Pain can even be seen as productive, as in childbirth. However, if the cause of the pain is indeterminable and it becomes chronic, the person loses control, which is seen as a crucial negative component. Increasingly, explanations and mechanisms to help to 'cope' become attached to the external world, and may incorporate existential beliefs. These may be spiritual, even religious, or may be a search for rationality. Many of the respondents cited the need for knowledge and information to provide reassurance and sustainment. The attainment of these qualities can be shown to be dependent on a person's status in the social structure. It follows that inequalities in status such gender, race or class may act to marginalise access to such strategies. This point is taken up in detail in Chapter 8. The theme of social acceptability of the appropriate emotional expression continues in a somewhat different form in the next chapter, which presents respondents' evaluations of the situations of others in pain, through the medium of visual imagery.

## **CHAPTER 7**

### **FINDINGS FROM USING VISUAL IMAGERY.**

This chapter provides an analysis of the data generated by the visual imagery technique outlined in Chapter 4. Responses to the images are first evaluated by gathering together and comparing the reactions to each pair of images in turn, and examining these for common themes. The size of the sample made this manageable in practical terms; material gathered in the questionnaires and interviews is drawn on for interpreting individual responses. Secondly, an assessment is made of the advantages and disadvantages of this exploratory technique as a research tool.

#### **An overview of reactions to the images: common themes**

One of the most immediately striking features of the responses is that, despite the diversity of backgrounds of respondents, and their different levels of articulation, the content of each pair of images produces very similar responses, and an 'over-arching' view is apparent in each pair. Each pair of images will be presented, with a selection of quotes which reflect the 'majority' view or interpretation, even though they may be articulated and expressed in diverse ways. Each pair also gave rise to reactions which were interpreted quite differently, and this 'minority' view is also expressed to try and provide a balanced picture:

**Pair 1**

**A. The Sick Child by Edvard Munch (1907 National Gallery, London).**

**B. The Hopeless Dawn by Frank Bramley (1888 Tate Gallery, London).**

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES.

A

B

On the whole, picture A is seen to be more concerned with physical illness, also to be more distressing and conveying pain. The theme of emotional pain is expressed continuously, sometimes with ambivalence, and many of the interpretations of the pictures are concerned with defining the **type** of pain:

'They don't seem to be in physical pain there, seems to be mental pain. She's sort of er that one there that seems to be in bed and the other one holding her hand or something, (A) maybe she's dying - looks like an old sort of Victorian thing.

**Q: Who's suffering the most?**

Well, physically her [A] and mentally her [B] because shes' giving the impression that if it is old times, then maybe the diet or health isn't very good but she's only contracted what she's got in the last couple of years - maybe cancer or TB or typhoid or whatever it is they catch, she's only had it in the past couple of years but she looks like she's had a hard life all

along and whatever she's got left she's still going to have it so.. pain, actual pain she seems to be suffering worst but she seems to have broken down, she seems to have broken down -they seem to have got me, the bastards, there's nothing I can do about it - it's funny really.... M1

In [A] grief and stress and misery - that's what I immediately focus on - it seems to be that the woman at the bedside is expressing greater grief than the patient- my immediate feeling is that she's the daughter and she is looking almost with a calm expression of detachment almost a feeling of slight satisfaction on her face.. Then I look at the other one .. it's a rough night outside, perhaps they're waiting for the fishermen to come home but to me it's too simple an expression of pain and grief - I can't feel my way into that, to me it's the other one which for me is the much more moving one which is much more baffling. M10

Respondents included personal feelings and experiences in their interpretations:

'Very emotive, reminds me a lot of my own illness - the figures in both must be mothers and daughters and they remind me of my mother and the care she gave me, how distressed she was.. [A] is most distressing - [B] looks more as if her boyfriend has left her or something - I don't mean that's not painful but the other one looks as if she's very ill, dying..' F1

'The one that gets me more is [A] - it's a deeper sort of pain - [B] just looks as if she's been dumped by someone - a lover or something and she's a bit upset, very upset but [A] is obviously suffering - the child is looking after the mother, there's more emotional pain. Well they're both emotional pains but [A] is far more extreme - it makes me feel sadder.' F6

'Well [B] looks like emotional pain - she's crying to her mother because her boyfriend's left her or it could be that they are both in pain because somebody's died. The other one, it looks like the person in the bed could be in physical pain and the person by the side of her could be in emotional pain but there is a physical pain there whereas that I think is purely emotional. That [A] is more painful.. it's strange, I was talking to my sister about when my mother died the other day and she was very, my sister was talking about how she felt nursing my mother through cancer, being in pain, so that really makes it stand out.. 'M6

Maria F9, gives a more direct interpretation of physical pain and illness:

'That lady looks like she's got arthritis or something [B] and she's in terrible pain. I do feel sorry for people that are ill - it upsets the home doesn't it?

Q: Is one worse than the other?

Oh that lady there with arthritis, I think that's a terrible disease really with her hands the way they are crippled up - the pain of arthritis is terrible...' F9

Only two respondents did not think these images portrayed pain at all:

'They don't really make me feel anything, I mean they're quite interesting but they're not necessarily about pain.' F3

'Well, in [B] the woman is very upset and in [A] she seems to be praying for the recovery of the child..'

Q. Right, what do you think has happened?

The husband has walked out.. he's tired of his mother-in-law [B]. This one [A], there's somebody on a sick-bed and they've just come through a crisis, recovering..'

Q. Is there any pain in either of those pictures?

'Well with the deserted woman.. in this one [A] the woman is exhausted I think, destined for a crisis but there is no pain there..'

Q. Do either of them make you feel anything, sad or upset or..

They're only pictures.

Q. So do either of them make you feel anything?

No. M5

The reaction of Daniel is different, in that, although he did not describe what is happening in the pictures as pain, they do stir feelings in him which he eloquently describes:

'My reaction to looking at this is that there is a story, I could go into a whole story but I don't know if that would end in me seeing pain or not. To be honest I don't see any pain - that's a human condition- I see care, I see comfort, I see love actually, especially in - [B] Both of them together don't show anything to do with pain... [A] is more physically... it does stir those emotional areas in me, I prefer it because it's reversed the roles to some extent in my imagination in terms of the person in bed who may be ill, dying even.. but I still don't see pain as such...M8

## Pair 2

A. Jamshedpur India by Werner Bischof. (1951 Magnum Photofile)

B. Old Man Grieving by Vincent van Gogh. (1882 Van Gogh Museum, Amsterdam.)

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IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES.

The reactions to these images again reveal a common theme. The choice of these particular pictures was influenced by the fact that, as well as portraying gender, they also raised issues of age, class and race. Of all these social characteristics, the main focus was on race and class, unanimously seen in the context described above, as symbolic of 'third world' deprivation:

'I think it's very difficult to know in the rich west what it's like to have to beg for bread to know what those feelings are. I think if we are reduced to begging in this country our feelings are quite different from people who beg in a society where a much bigger percentage of the population begs, where it's much more acceptable than it is here. Part of our outrage at seeing young people begging in the streets which has become so much worse over the last what 5 years is that we thought we had eradicated it and we're outraged that it should be back whereas in India or wherever this is it's always been there and people grow up with it and it's there and I don't know how one would react to that as being part of a society in

which that was the norm. I mean one can be outraged that she shouldn't jolly well have to but that's making a judgement on a society that one imperfectly understands though I wouldn't wish to sanctify begging on the streets - it's never an acceptable way that human beings should live but its very difficult to sort that out- it excites pity.' F7

The man's plight is seen as private and personalised, whereas the woman is seen as representative of a universal suffering, the public 'pain' of the underdeveloped world.

'This one [B] conjures up the pain of the individual whereas this one [A] is the more harrowing picture-graph and it makes you aware of the plight of people. Maybe, not for me personally, you'd think it was less of the plight of an individual, you'd think more of a people, a group of people but also it can re-identify the fact that there are individuals when you talk about problems such as famine or, it could be anything whereas the drawing - if you know a bit about Van Gogh it picks up the artist's pain, a man creating pain, in inner turmoil - I can probably relate to that more but I suppose if I'm honest this is the more moving because there's something more contrived about an artist, especially when he's a famous artist..' M4

'Well, I think there's suffering in this picture [A] but it's... perhaps one projects ideas on to these things, that's what I'm doing -but it's more like a universal suffering rather than a personal pain. I know that kind of picture quite well and I could go on for hours... But the second one [B], I don't know whether this man is thinking or whether he is actually suffering. Because of the nature of the subject you've given me I'm biased - I'm looking more at the drawing than I am looking at the human figure who could be possibly crying, possibly thinking but its more about pain than [A] - that doesn't equal for me again, pain as such. Universally maybe yes, but its not personalised, it's more universal suffering, that's what I see.'M8

'Strangely enough, [B] is more um, sort of hopeful - [A] looks like Ethiopia, India or something, the starving... there's not much light at the end of that tunnel. But [B] a grown man crying, he obviously looks quite old - I don't know I think it makes me sadder - it's something that's happened to him that's more emotionally painful, it's different. But this is sort of more environmental - what's happening around is explaining- that's what's affecting her. But it's probably worse really.' F6

Whether or not the content of the pictures are defined as pain, the 'public' nature of the plight of the woman appears to act to reduce empathy for her; even though there is a consensus that she is probably suffering more, his personal grief seems to produce more immediate sympathy:



'I feel upset looking at him - that could be me when I get old, I don't want to end up like that. He's probably fought in the war, all sorts of things but just to end up in pain, old, alone - he's probably got cancer or something... I know she's probably even worse off, she could be starving even but I'm much more sorry for him.' M2

'The man is in anguish, what he's going through is certainly not pleasant but it's a personal anguish whereas the woman - it should be more shocking - I don't know if it's because it's a photograph but I don't know also whether it's pain- it could be death, loss, torture, something happening in the body but it's not personal. Both represent different things.F8

There are responses which do not consider these images to convey pain as such:

'They're more a familiar picture of despair more than pain - they're more of hopelessness... both of them...' M9

'The man is angry - he's lost everything through his own fault, he's lost all of it - it's like an omen that happens every 10 or 20 years. It's possibly grief but also despair, its not physical pain but emotional stress. For her, after many years of anguish maybe there's some hope - the person taking the picture represents hope. There's on overkill on TV of this type of thing but it makes me feel like I would like to be able to help, to do something.' M7

## Pair 3

- A. The Lady of Shalott by John William Waterhouse, 1988 Tate Gallery, London.  
 B. Melancolie by Edvard Munch, 1918 Munch-Museet Oslo.
- 

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES.



This pair created a strong emotional reaction, in that the majority of the sample did not think the images portrayed pain at all, although there was a much more sympathetic response to image [B]:

'That's quite a stark sort of picture [B] - I do think it's horrible, the black and white.. it's not conveying anything, just a sort of incredible desolation. With her there is suffering in her face, not agony but not much joy, it's a romantic sadness but it's preferable to him, he's in more pain..' F5

'I hate the romantic painters... [A] she looks like she's in liver- failure [laughs] - it's not painful, it's like a Flake ad almost, like a panda, bashed round the eyes maybe but she's asking for it going round like that [B].. but that one shows real depression - that's the loneliness bit but not like pain.. although I suppose if you feel really low and really sent to Coventry by your peers that must be painful. That makes me feel sadness... but that one [A] just makes me feel slightly sickly sentimental..' M2

'No, no, they don't do anything for me - it's just despair, it's not pain, maybe you see them differently.' M9

Even if the woman in picture [A] is seen to be in pain, it is seen to be the pain of 'romantic love', which is portrayed as being rather ridiculous, not to be taken seriously, and certainly not 'real' pain. Some respondents even indicate a narcissistic self-inflicted quality, whereas the loneliness and isolation of the male figure [B] is seen as a more valid form of suffering:

'[A] If you had to die, that's the way to go.

Q: Is there any pain?

Emotional pain, yes. There was enough emotional pain for the Lady of Shalott to end her life and for him, there's pain, a heartbreaking sort of pain. My sympathies are more with him - I don't like martyrdom really or maybe I'm just not in a very sympathetic mood.' F6

Q: Is she in pain?

Yes but possibly quite enjoying it. I know that sounds very cynical and I wouldn't have said that 20 years ago, I'm sure but yes, she probably feels she is but sort of pain and love and beauty are sort of all intermingled. The second one, I really had to look hard at to see him, which if it were an autobiographical thing would show that the person had very low self-esteem. Even now the person is saying it looks so hopeless, it's almost like a sense of himself merging with the surroundings. He could just be thoughtful, when I look closely at his face - again he makes me think of somebody withdrawing because they can't face themselves or outside. I think I'd choose him in that he looks more like a real life person.' F4

Only two of the respondents appeared to empathise or feel there was any genuine plight in picture A, and both these respondents named picture A as the one they most identified with:

'This girl here it's hard to say she's a lady that was in love or something she's all forlorn-looking isn't she? She's in pain, she looks as if she's heartbroken. With this I can't make out that - is this an ocean, a water or what, somebody drowning with their hands up - oh when I have it close enough now I can see his face - he seems to be um right down and out doesn't he, as if he is tormented - there's something really worrying him isn't there? I think she's bad - she's heartbroken, or she's lost someone so

she'd be more likely to do away with herself - I'm not saying this gentleman, he's not in pain but I think she's worse, I feel very sorry for both of them but she's like me, she's lost her man.'F9

'She is showing the pain of an inadequate world - a melancholic love of life as known by her, a more esoteric life. He is really black and white - lonely, empty - a black snake in a human body. There is no emotional comfort there whatsoever, I used to feel like that in the mental hospital, I'd rather be the woman.'M7

#### Pair 4

- A. Saint Sebastien by Gerit von Honthoust. 1590 National Gallery, London.
- B. The Broken Column by Frida Kahlo. 1944 Collection of Dolores Olmeda, Mexico City.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES.

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A

B

For the first time the images actually depict physical pain being inflicted on the subjects. This invokes mixed reactions - of fear, of revulsion, and, when viewed initially, [A] is seen to be in more pain than [B].

'Ah, that's in a foreign land isn't it? He reminds me of Jesus.. and her Good God.. this is really bad but she doesn't look in pain - she looks forlorn-looking not wild looking but she seems to be in another world, you know.. He's in the most pain, like Jesus on the cross, it's terrible, really terrible...'F9

'Well, I don't know what he's done to get all those things stuck in him, he doesn't look in pain but he must be, in great pain. She's not a real person, it's probably worse but she don't look real to me..'M9

'She's been tortured into confessing something like witchcraft and he looks like - he's obviously been tied up to be killed but he's obviously been humiliated first - there's one through his leg and one through his arm so they've obviously made him suffer that pain first and that one in the stomach would make him suffer whereas this one is aimed right at the heart - it looks like he's been made to suffer, the two of them have but she probably suffered the worst - with all them pins and that she's obviously been made to feel terrible pain - in some of the things they did to people, I've read up on it.' M1

Sado-masochistic themes were seen by many of the respondents, who found them disturbing:

'Both these two are having incredibly painful things done to them but they don't seem real, they seem like concoctions or creations, especially the woman, she's like a robot. They conjure up visions of acupuncture to me - which may not necessarily hurt much at all. The nails in her breasts quite disturb me because they do look realistic but otherwise it's just like an intellectualised appreciation of pain. I suppose if I chose I would say he's in more pain because it must be pretty excruciating having arrows through your arms and things, but he's not showing pain, it's not at all emotional but fascinating in a cold way.' F1

'It's funny because when I see pictures like this I can look at it very dispassionately and be worried about the poor guy's spleen or something but.. it makes you wonder why on earth anybody would want to have that picture on their wall - not that I don't feel sorry for San Sebastien. As for the other one, well that's just weird, that is. It's somehow deliberately - well both of them are pictures of deliberately inflicted physical pain, either by somebody else or by themselves, I'm not sure who would stick drawing pins in this poor woman but I find them a real turn-off - I don't understand it, it doesn't play a part in any part of my life or of my relationships... this one disturbs me more but it's very hard to say because if she gets some sort of kick sticking drawing pins into herself then it's not necessarily more painful than having arrows stuck into you..'F10

This is San Sebastien - there is almost something like a narcissism of pain. People sometimes talk in terms of sado-masochism in relation to this subject and so I'm not very surprised that there's an element of sado-masochism in the other picture - there is horror in both of them but I have a feeling of almost some faint pornography - the eroticism, the mixture of pain, pleasure, bondage suggested by the bands around her waist - it's a nasty picture but also I must say I find it faintly attractive, compelling - images of crucifixion. But there's something sort of sado-masochistic about it that I don't respond to or if I do I'm perhaps ashamed to acknowledge. The San Sebastien - the beauty of the body, the face, the painter has enjoyed putting the arrows and the blood on the body - it's quite

disconcerting...' M10

The San Sebastien, I don't know if that's pain, it's almost sexual, it's about something else.. he's too prettily poised.. As for her, she's not a real woman, it's an image of a woman.. neither of them are about pain, they are symbols of something else.' F8

The lack of expression in both the faces obscures the reactions of many of the respondents, resulting in a "distancing" of feelings, sometimes attributed to the artistic style:

"This is.. is frightening (B) but it feels more like a Yogi in its feeling - the idea that you're seeing inside of a person with a broken column inside being held together with straps - a broken landscape too. It's trying to talk about pain but my feeling would be to make it much simpler.(A) This one with the arrows is more, the idea of pain is in seeing the arrow coming out with the blood, there's a certain feeling of thud about it but at the same time you kind of feel slightly divorced from it, partly due to the lighting - it feels like a theatre stage set so in a way it gets you in the pit of the stomach but you don't necessarily think in terms of pain in terms of the picture, you're more thinking in terms of what the spirit is doing, in terms of what its about - I think that is the purpose of the picture. My feeling is that it is trying to talk about a certain type of pain - more like an intellectual exercise. In a way I'd feel like the picture would be enough if I just had one or two of the details- I just feel that the body in itself is sitting there, it seems impervious- I would feel that it should be reacting more. I mean in both cases you would feel there should be something more - when you see someone die, I mean it's not a necessarily peaceful occupation... that passivity, acceptance. Definitely this feels like a mantra, a Hindu interpretation of life in which you're really passing through to another stage of life. I suppose there's more pain in this one in the way you can read it in. M3

Neither of them particularly, well they're both symbolic in their own way- I mean it conjures up feelings but not emotions. The pain from the one on the right(B) is about what you should be feeling and you will feel but you won't.. well I think that it represents pain but I don't think you can feel it from that image but you are aware of what it means -the pain is made real. It's symbolism, when you're not actually feeling it your gut but you feel it in your head... The other one is ..is too clean, you know what I mean, it might as well be done like with an airbrush. Maybe if you're really religiously inclined then any image of Christ's suffering is going to stir... but there are so many really harrowing stirring images that this is not comparable. Again it might conjure up his suffering in your mind but not in your heart. If I had to say, I think [B]is more evocative. M4

## Pair 5

- A. Scene from a London Playground, Network Photographers. 1987 Aladdin Books Ltd.  
 B. Hungary 1947 by Werner Bischof. Magnum Photofile.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES.

A

B

This pair of images gave rise to the most immediate emotional reactions, usually of sympathy or pity. Most of the subjects claimed to feel upset or distressed by looking at them:

'At first sight they both have a big impact and make me feel upset but I don't know why they're crying - I would think that the black child is in more pain, it seems more intense and there may be racist implications there whereas the other child may be upset because it's been sick or something.F1

They're both in pain, they're equally upset and both very sad, both suffering. They stir much more emotion in me than anything else I've seen.'F3

The black child on the left is in far more pain, he's in agony whereas the child on the right is sort of dazed. They're both equally as sad but the black child has more pain.F8



Although they're both crying, the anger is very visible, especially in (A)- they're angry and resentful. Kids do get upset quickly, of course but it often passes but if its emotional pain it can be buried deep. From the expressions on their faces (A) is probably in more physical pain. F10

Well, definitely the one on the left (A), it just appears more real, more authentic, more hurt. This one might affect people because he's a more beautiful child or because he hasn't got the grimace of pain on his face, he just appears as if he's just stopped crying but the realism of what he's going through, the pain, anguish...

**Q.** Does it actually make you feel anything?

Yes, it does, it does.. just that one not the other, I mean he's cute but this one is really in trouble... M4

The one on the left especially [A], the expression on the face, which is what we are conditioned to reflect - there is more suffering - there is some in the one on the right but there is more in the one on the left... looking at these pictures, they're quite strong because I don't see him with a nail in his foot and I don't see him necessarily with his bottom smacked - although maybe more there - I see much more despair there than I do here but then maybe that's photographs- you show me a photo of him in this much despair and I'd say yes - or reverse it. Certainly the one on the left, anyway. M8

[A] has more immediate impact... he's crying, he's out of control and to me that's the deeper pain - more immediate, more physical, his head, his body is out of control and the attempt to comfort him - the hand of the adult - I don't know whether it being white is relevant or not but there's no reaching him, he's sobbing uncontrollably. There's a grave, almost stoic look about.. of course one is moved by both of them because one hates to see children in distress but I feel more pity for the one on the left. On the other hand its probable the one on the left will probably be laughing and joking whereas the one on the right will - his melancholy will probably be a more long-term one because he's looking out so steadily at life - looking out so clearly and strongly and sternly - it's almost philosophical.. M10

However there were three responses which were very different from the others - from the two oldest people in the sample, one male and one female and the youngest man:

'Well, he's been told not to play with his white school - children friends and the boy on the right is the boy that he's been refused to play with and he's having a few tears.. it's like race relations but it's not pain, just childish tears and having disagreement or being told not to play with each other..'F3



'You don't take children crying so seriously so much now, it's become a bit of a cliché- This one [A] it seems more like he's genuinely crying about something.

Q: Right, so what's happened to this one?  
Oh, he's had his sweeties taken away or something.

Q: Do either of them make you feel upset or anything?  
Not on such a lovely day - it's a bit like a film - when you see it on a big screen it's exclusive, it does something but if you see it on TV it doesn't...'M2

'Yes, but children cry. Small children can be absolutely heartbreaking for the lack of another Smartie - you can't always take it so seriously, tremendous tears, upset- they don't look in pain..'M5

## PAIR 6

- A. **Two Followers of Cadamus Devoured by a Dragon by Cornelius van Haarlem. 1624 National Gallery, London.**
- B. **Judith Decapitating Holofernes by Artemisia Gentileschi. c.1618 Uffizi Gallery, Florence.**

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*IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES.*

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The final pair again depict gory, violent images, and produce some responses of horror and refusal to look at the images.

'I don't know what to say about these - they're both so revolting I don't even want to have to look at them..'F10

'Oh good gracious, I can't see them properly, thank goodness. My immediate reaction is sort of bewilderment but.. tell the library to give you some different pictures...'F3

'Oh good God that's a sacrilegious thing isn't it, they're cutting his head off, good God and they're cutting his throat - this is terrible what they've done, this is the worst one, they're crucifying him, cutting his throat and it makes me shudder - that one does as well but that is worse - it upsets all your system as soon as I look at it...'F9

Again, there was a process of 'distancing' from the horror portrayed in the images.

Discussion of the artistic style was often used to create this distance, by employing an analytical, more intellectualised response, which serves to reduce the possible distress:

'I just can't imagine why anyone would want to paint pictures like these.. That's just like fantasy to me - I don't like it but I just kind of accept it and I suppose that's my first impression of it.. Both those scenes are a bit unreal- my initial impression is almost sort of annoyance that someone would create a picture like that. I think that this one is sort of beyond pain but the other one shows a sort of desolation.' F5

'Very unpleasant - like something out of a horror movie. There doesn't seem to be a lot of pain in there - it's gruesome basically. There's an inevitability about it - that expression is a lot more um, pained - but the expressions on their faces - we're going to kill you so there so you may as well just lie back and enjoy and he isn't struggling much, it doesn't seem- there's a childlike quality about it like young children pulling off the legs of ants and frogs and things, not caring. And the dragons - obviously they did something naughty but of the two that is the least - none of them are pleasant but I like dragons...'F6

'Bloody hell, that's one way of getting rid of the husband isn't it? Well this one[A], makes me think of those sort of films - like Friday the 13th or Nightmare on Elm Street, Well this probably some sort of devilish thing, something very unholy and evil - you can see someone's had their head ripped off - that sort of thing makes me think at times I wonder what sort of mind people have got to - er dream that sort of thing up... For this one

[B], I feel that could be me, it could happen to anyone but this sort of thing doesn't seem real, it's more like Spielberg or something, I don't identify with that because I don't like that sort of film, I don't like people getting killed, I don't like those pictures, it doesn't do anything for me at all but that one I don't see as being real, it's more been created for the camera or the painting. This one I can familiarise with that more because that is real, has gone on, did go on and still goes on now - it looks like he's been asleep and they've come in and caught him by surprise, by the time he's realised what's happened it's too late he can't do nothing to save himself so I feel more pity for him, you know, make sure you lock the kitchen up.. they could have killed him for a number of reasons, judging by the look on their faces it could have been mother and daughter, he could have been a murderer or a rapist, anything like that. I think that's a bit sick really..' M1

'It is difficult to portray pain as such isn't it - you can put it in terms of theatre which this is... That's meant to be George and the Dragon in the background I think. I imagine this is meant to be a lady but it may be a man. I mean that has a feeling of the hope behind the disaster. This is more ruthless, it looks like an illustration from the Bible - one of these final solutions. I'm afraid you have to say that because he's been caught in his sleep, there's more pain involved here. At the same time, this looks like a corpse, this bit - but it doesn't feel like pain as such. This has more - you see that face, it could have been taken from a cadaver or something. It turns your gut but not in the sense of pain. I suppose I could say I'm surprised it takes two ladies to get a bloke while he's asleep. There is a certain amount of pain in that face but it's more pain of surprise than pain of pain. You can feel from this that the person is obviously rich but there's no real clues to why, I suppose it's revenge.' M3

'Where on earth did you get these? I think that's the worst one actually, getting murdered by two women, unless they're trying to help him commit suicide! He must have been a terrible husband or father, or whatever... This one is pure fantasy, very unpleasant but that's worse because it's more probable. Presumably there'd be a lot of physical pain there but not a lot of emotional pain but there obviously there's been a lot of angst about what the relationship is, unless they're female burglars. But it looks as if they're fed up with this guy who's led their lives quite a - and they're taking it out on him..' M6

At the end of the sequence, respondents were asked to look at all the images together and, if possible to choose which person was in the most pain and which person they identified with most, depicted in Figure 7:1.

**FIGURE 7:1 Respondents' choices of images depicting most pain and personal identification.**

		IDENTIFY WITH MOST			
		MOST PAIN			
		Females	Males	All	
					All
1.					
A)	Sick child	4	-	4	1
B)	Hopeless Dawn	-	-	-	4
2.					
A)	Jamshedpur	2	1	3	-
B)	Old Man	-	-	-	3
3					
A)	Lady of Shalott	-	-	-	1
B)	Melancolie	-	2	2	4
4					
A)	San Sebastien	1	1	2	-
B)	Broken Column	2	2	4	3
5					
A)	Playground	2	3	5	2
B)	Hungary	-	-	-	-
6					
A)	Devouring Dragons-	2	2	-	-
B)	Decapitation	-	-	-	-
TOTALS		11	11	22	11
					22

The crying child (5 A) was given the highest overall rating for 'most pain, and was the most popular male choice whereas 'The Sick Child' (1 A) was preferred by females. 5 A was again the choice of identification for both men and women, but equal ranking was given by females only to 'The Hopeless Dawn'(1 B) and by males only to Melancolie (3 B).

### **Links between the public and the private: advantages and disadvantages of using visual imagery in data collection**

On the whole the subjects responded well to the request to look at and discuss visual images. Nobody refused to take part, and most respondents claimed to enjoy the exercise. Some even claimed to find it therapeutic. This was especially so of the subjects who had experienced traumatic treatments involving hospitalisation (for example, Peter (M10), who had undergone radical surgery for cancer, and Rachel(F10),who had several operations on her leg after a road traffic accident), or severe emotional disturbance (for example, Michael (M7), who had received long-term treatment for paranoid schizophrenia, Tim (M4), who was experiencing constant debilitating anxiety attacks, and Jane (F7), who had experienced a long period of distress and despair due to her son's mental illness). All these respondents expressed the view that contemplating the plight of the people in the images somehow helped to put their own dilemmas into perspective, and gave them an opportunity to 'cope' with the feelings that their own personal events had thrown up for them. In the same way that Finch (1986) demonstrates how the vignette technique provides a form of 'desensitisation' - an acceptable way of talking about the private in public - many respondents claimed it was a relief to take part in the imagery exercise after having revealed in some depth their own 'pain stories', and to

contemplate something that was happening to someone else.

This densensitisation was mutually beneficial, from the point of view of 'the burden of interviewing'. As can be seen from the case-studies, many of the 'pain stories' were extremely harrowing to listen to, so the chance to turn to something more distancing was personally relieving.

An important methodological issue is that using images enables the subject-matter respondents are asked to react to be standardised - the images stay the same, whereas questions may alter in context or expression from interview to interview. A second important methodological point is that the use of images gives rise to an immediate response, and does not necessarily require a high level of articulation, although obviously how people talk affects what they say. Preliminary discussions about using this type of material had raised the issue that some people might relate to artistic representations better than others, in other words there would be a social class advantage in that the higher social classes would be more familiar with the materials. In fact, given the responses from this sample, this would not seem to be the case. Obviously, there were differences in the styles of articulation, and people with an artistic background or knowledge discussed the images more analytically, to the extent that they sometimes became inappropriately diverted by discussing technical styles (for instance the merits of photographs over paintings or vice versa). It appeared that the less the respondent knew about the picture, or art in general, the less contrived was the response. Comparisons were often made with television programmes, popular novels or media advertising, and the quality of responses was very rich and philosophically profound, as the quotes illustrate. Even the subjects who felt that the exercise was pointless (Suni (F3) and Bob (M9)) did not refuse to take part, and made appropriate and relevant contributions. The

only person who was unable to use the material at all was Helen (F2), as her eyesight was impaired by her accident, and she was unable to decipher many of the scenes, but still attempted to do so with my assistance. Marie (F9), who was unable to read or write, participated enthusiastically in the exercise.

The literature review in Chapter 3 showed how most studies of pain perceptions use the infliction of noxious stimuli to demonstrate psychophysical laws. By contrast, an investigation using interviews and visual imagery is far more 'person-centred', and can be experienced as supportive. The inherent advantages would seem to offset the more practical difficulties in presenting material of this nature. Written accounts require complex reprographics in order to be able to convey the images, and presentations require audio-visual aids, but the resulting richness of the data justifies these efforts.

## **CHAPTER 8.**

### **PAIN AND GENDER.**

In Chapter 2, a review of the literature demonstrated that biological differences and theories involving sex-roles, the cultural socialisation of males and females, and stereotyped assumptions of health practitioners may all constitute possible explanations of gender differences in health and illness. A theoretical framework of a similar nature may be useful for explaining differences in perceptions of pain.

One of the main research questions outlined in Chapter 4 asked whether there is a relationship between the role of gender and perceptions of pain, and in particular whether there are cultural assumptions about the ability of women and men to 'cope' with pain. The questionnaire findings in Chapter 5 supported the view expressed in other attitude surveys, namely that women were thought to be more able to cope with pain. This finding is discrepant with much of the psychophysical research, which tends to favour women's pain thresholds being lower than men's (see Chapter 3). Open-ended material collected in the questionnaire asked respondents to articulate the reasoning behind their views on gender and pain; analysis of these data revealed a variety of reasons and beliefs, many of which are extremely complex (see Chapter 5 Figures 5.1, 5.2, 5.3 ). These sophisticated explanations often transcended the dualisms perpetrated by scientific divides of mind and body, nature and nurture. It was hypothesised that the potential flexibility and subjective nature of the interview would act to cultivate further contemplation. The aim of this chapter, therefore, is to draw on the interview material in attempting to 'tease out' gendered notions of pain.

#### **Questionnaires versus interviews**

After respondents had talked in detail about their most painful experiences (which in



turn, opened up discussions about the nature of pain), and had considered the visual imagery they were asked to comment on, they were reminded of the questionnaire, and asked if they could remember what they had said in answer to the question as to whether they thought there were any differences in the abilities of men and women to cope with pain. Of the 20 men and women who fully completed the interview (two respondents began the interview but did not complete it), nine remembered their answers accurately. Seven respondents changed their opinion completely. (see Figure 8:1).

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**FIGURE 8:1 Perceived abilities of men and women to cope with pain: comparisons between survey and interview responses.**

SAMPLE NO.	QUESTIONNAIRE RESPONSE	INTERVIEW RESPONSE
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+ denotes response remembered accurately, stayed the same.

\* denotes response not remembered and changed response.

- denotes response not remembered, stayed the same.

F1	-	women cope better	women cope better
F2	-	women cope better	women cope better
F3	+	women cope better	women cope better
F4	+	women cope better	women cope better
F5		don't know *	women cope better
F6	+	women cope better	women cope better
F7	+	women cope better	women cope better
F8	+	women cope better	women cope better
F9	-	women cope better	women cope better
F10		no differences *	women cope better

M1		no differences *	women cope better
M2		no differences *	women cope better
M3		no differences *	women cope better
M4	+	women cope better	women cope better
M5		no differences *	women cope better
M6	+	women cope better	women cope better
M7		no differences *	women cope better
M8	+	women cope better	women cope better
M9	-	no differences	no differences
M10	+	women cope better	women cope better

---

Two women and five men gave different responses in the interviews from the questionnaires. These changes were all from the 'no differences' or 'don't know' category to 'women cope better'. There could be various reasons for the changed responses. One obvious explanation is the time interval between completing the questionnaires and the interviews (six months), which allowed for genuine changes of mind. Another possibility is the effect of the interviewer's gender, though as she also handed out all the questionnaires, it does not seem likely that this is the explanation. Indeed, other research findings go against this interpretation, in suggesting that in the presence of women men are more likely to say that men cope better. In an experiment conducted to investigate the effect of experimenter gender on the pain reports of male and female subjects, subjects (33 female and 35 male North American psychology undergraduates aged 17-29) were asked to rate cold pressor pain<sup>3</sup> in front of either male or female experimenters. The results indicated that males reported significantly less pain in front of a female experimenter than a male, whereas the difference in female subjects was not significant, although they tended to report higher pain to the male experimenters. The authors conclude that:

'The result is congruent with the standard gender role requirement of males appearing macho and not allowing females to know they are weak. The overall implications of this experiment is that pain report between the genders is not a simple difference of pain sensitivity. Rather it appears to be under the **social influence** of the gender of the person to whom the report is made' (Levine and De Simone 1991:71).

It is interesting to speculate whether the change of opinion that took place in the interviews would have been the same had the interviewer been male.

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<sup>3</sup> The cold pressor test is conducted by subjects placing their hands up to the wrists in a hard rubber bucket filled with ice-water and a layer of floating ice-cubes at a temperature of 0-1.C and rating the subsequent pain on scales measuring both sensory and affective scales.

Other studies (see for example, Oakley et al 1990), have noted the tendency for questionnaires and interviews to yield different responses. For certain kinds of data, it would seem that the more anonymous context of a questionnaire encourages the confiding of sensitive information. Although none of the men who changed their minds in this study could remember what they had originally indicated on the questionnaire, both women did remember. They claimed that their opinion had changed in the intervening time, due to personal experiences.

### **Why do women cope better?**

Nobody in the interview sample expressed the view that men were more able to cope with pain, and only one man, Bob (M9), maintained the view that there are no differences. His rationale was as follows:

'But overall, about the same - that definitely one way or the other as regards physical pain - I mean you've both got the same central nervous systems - what's going to hurt someone whether they're male or female - the pain is going to be the same. If it's not psychological then I would say it would be the same.

**Q:** What if it were psychological?

Well, that would vary between individuals, some people are far more sensitive than others - they feel - some are a lot harder through experience than others so it's easier to block out psychological pain. Like at this stage now, very little would give me too much psychological pain, I would just block it out and not dwell on it whereas someone younger would get very upset over things now I wouldn't blink at. I think psychological pain is an individual thing whereas physical pain would be the same male or female.'

In spite of worries expressed over making generalisations, everyone else in the sample stressed the view that women were inherently more able to cope with pain.

The relative informality of the interview provided an opportunity to examine in more depth why this opinion was so firmly held. Many of the men stressed that it was a popular belief, for example:

'It's difficult to say - one is brought up to think that women cope better with pain... I think they have a bigger threshold - whether that's a purely subjective view...' M3

'Oh, women are better at coping with pain.

Q: Why do you think that is?

It's er, sort of folklore but I think it's true.' M5

'Well, that's the only reason I put it, it's a general belief - women have to go through labour so... As far as I can gather it's just something in the make-up of women that's different to men... but whether it's something you can scientifically prove, I don't know... It might be one of those myths - like strength. A man is supposed to be stronger than a woman but women are stronger emotionally and can stand more pain.' M6

Childbirth is portrayed as the ultimate painful experience, especially by the men in the sample. For instance, Peter (M10), despite his personal experience over five years of malignant tumours resulting in amputations, still maintained that the worst possible pain he could imagine would be childbirth. He felt that in turn, women's ability to reproduce gave them a 'natural' advantage to cope with pain:

'My hunch is that has to do with childbearing, I remember a sense of awe and fear even when [his son] was born - I could hear [his wife] shrieking and screaming from where I was in the hospital waiting room. There was a sense that I would never know that extreme of pain that she was undergoing.

Q: Would you say that now?

Yes I would, and I do think that many men do have that awe and the sense that this is the ultimate pain, that there can be no worse and of course we don't know and we can't know what childbearing is like. And there are many different attitudes towards the pain but as far as I can gather most women seem to feel it's worth it.'

The view was repeatedly expressed by both women and men that the combination of female biology and the reproductive role served to equip girls and women with a 'natural' capacity to endure pain, not only physically, but also emotionally. This 'natural' attribution of women re-evokes the well-known distinction between public and private domains. Amongst others, Martin (1987) points out that women are intrinsically linked

with the family, which is the location of bodily and 'lower' functions, whereas men are more readily associated with cultural, mental and 'higher' processes of the public world of paid work. This theme recurred frequently in connection with pain perceptions and beliefs, and was articulated by all the respondents in some form:

**'I suppose one naturally expects women within the course of a healthy life to be involved with pain but not men on the whole - unless they get hit with hammers.' M3**

**'I wouldn't think it's a learnt thing, I think it is an actual biological difference. Although there might be women who are brought up to - well be beaten all the time, they might get used to it, like battered wives or something.' M6**

**'I think partly because women are more in touch with their feelings and they have certain yardsticks, not just having babies but periods, things happening to their bodies that they aren't in control of so they think about their bodies more and they learn to live with discomfort, I suppose. Most people find periods uncomfortable if not painful, and the same about pregnancy - some women enjoy being pregnant but others find it mildly irritating and uncomfortable. Even things like breast feeding - when do men ever experience anything like having cracked nipples but still carrying on with it - things like that. I think women just have more contact with their natural biological part and they are just more inclined to think about it and analyse it and not just complain about it which I think, well in my experience, is what men do, really. They're not really interested in the causes of pain or sort of in seeing themselves in relation to the pain, but they think of it as an outside irritant that's got to be dealt with.' F4**

As in the open-ended data generated by the questionnaire, the interview revealed sophisticated explanations ranging right across the biological and socio-cultural frameworks described earlier. Although many explanations began with a biological basis, they led in to role expectations:

**'Women are made to suffer pain because we have periods and childbirth. Whatever happens, women end up bringing up children, we just don't have the 'privilege' of giving in to pain and sickness.' F3**

**'I think that women cope better or have to cope better, well I think they have to because a man can go off to bed if he's feeling ill but a woman has still got the kids there or they're not really allowed to be ill - they don't think, she still has to get the jobs done - the kids are screaming for**

attention they don't really understand that Mum 's not well 'cos if Dad's not well he'd be in bed... so I'd have to say that possibly it's worse for a woman, physically and mentally probably because they're not allowed to show it. The man only has to provide the earnings, well in a lot of cases the woman has to provide money too... so women suffer more - it's a man's world really in that respect.' M1

'I mean people do say that women can take more pain and this does seem to make sense to me but I think it's probably that it's different sorts of pain and I'm a bit wary of generalising. I think men have more fear really which is what enables one to take or not take pain really- I think it's when you're afraid to some extent that you come apart..in a spiritual sense women are stronger - women are much more spiritually orientated than men and I know there are many men who also are but for women it comes much more **naturally**. Also women can... well in our society we've got so confused about gender roles but in simpler cultures the women are used to doing the serving and so if something happens to them the attitude is more - oh I can't give to others rather than what's going to happen to me...' F5

'I think women are much more stoic. I think women have a very strong sense of responsibility. I suspect that's developed by society, that's what they're expected to be but also some of it is inborn and that the propensity is there because of the protection of children and the next generation. Human children take so long to grow up - you have to be responsible for them a long time - so women tend to put their pain on one side while they get on with being responsible so in fact the needs of other people override the need to experience your own pain - I think particularly emotional pain. Physical pain, too, I think an awful lot of women just get on with their lives and maybe men too, so I'm not sure if it does split by gender but certainly the responsibility for small children does but that isn't the whole story... when you come to emotional pain, I think practically everybody runs a mile and I think women are better at expressing and acknowledging emotional pain than men are. Now ask that question again in 50 years because say 20 years ago, 99% would never have admitted to emotional pain anyway - that's something that the women's movement, women's liberation - that's what women have been liberated from in many ways - this need to cover up and pretend everything is alright - they somehow find it possible to express and acknowledge their pain. But men are much worse at it-maybe they're more frightened - but it will probably come because I think there's a movement throughout society, more credence to the individual - there are different balances of home, leisure and work.' F7

### **The conditioned stoicism of men**

The theme of gender socialisation was also interwoven throughout the explanations. In contrast to the 'natural' biological capabilities of coping with pain attributed to women,

it was felt that childhood socialisation actively discouraged emotional expression in boys, and adult males felt an obligation to display stoicism. Subsequently, the experiences of many men and women are that for men pain of any sort is abnormal and outside their expectations, and they are consequently less able to deal with it. Thus according to Gina (F6), aged 18, who had grown up in a household with some experience of 'role reversal' in that her mother worked full-time, and her step-father worked part-time and carried out most of the housework:

'Men are not allowed socially to express pain as much they're supposed to be stronger. We're allowed to cry and they're not... although women have more breakdowns than men, men don't allow it to come out, they hide it until it's unbearable whereas a woman will usually say 'I can't cope' long before. It's hard to avoid the indoctrination - you know men are stronger, therefore they could stand pain more but if I think about it logically I don't really think that... women can cope with mental pain a lot better. My parents are divorced and I know that my father still cannot cope with that, with the pain associated with the divorce and the things around it whereas my mother has come to terms with it and is much more able to give. Obviously in her mind she has dealt with it and analysed it, done it to death really - worked it all out, why this happened and that happened. But as I said, it does depend on the person - I do have male friends who are extremely sensitive and very analytical. I'd say perhaps 40% of my male friends are expressive and emotional whereas perhaps 90% of my female friends are but you can't really say whether that's biological or society- in the social environment people think it's a sign of weakness to show pain but actually it's a sign of strength.' F6

James (F3) also lived in a household with some role reversal - his wife worked full-time as a doctor, whereas he worked as an artist from home, and had taken the major role in raising their two sons. He described a recent incident in which his youngest son, aged 9, had fallen over and cracked his skull. During the visit to Casualty, the boy wept continuously and profusely and was very upset. James expressed the view, rather apologetically, that he had felt his son to be making too much fuss, and expected him to be rather more stoical. He also admitted that he would not have had the same expectations of a girl, and also that he would not expect female child to have such an

accident in the first place.

The phenomena of 'macho' conditioning was a recurrent theme for many of the respondents:

'I think a woman would be more likely to seek help than a man would because I don't think a man would accept that there's anything wrong with them. Women would be the more sensible and the men would be more stubborn - It's a form of brainwashing, it's just - like at school you see a boy in the corner crying for his mum, but a girl it wasn't the same - the boy is a sissy or whatever, with the girl its a form of brainwashing, you don't even realise it like - boys its all action men and guns and you know, they're taught to be tough where girls have all little dolls and things to dress up. Apart from the odd exception the majority - it's done without even realising, its a form of brainwashing, television and everything you know, maybe it shouldn't be you know but that's the way it is, you're not allowed to show your feelings, you're not meant to but why shouldn't you? It's just not accepted. There are different cases but that's a general view of the way it is.' M1

'I think women of a certain age are ready to consider the pain of childbirth - they know about it. Maybe a 4 year old seeing a woman on TV biting and screaming doesn't know what's going on, but by age 8 they see, they learn, they hear and gradually the psychological resistance builds up - I believe in the power of the mind and that it affects the physiological threshold. I don't know if that's very clear but I think that men are - historically they've been in a position of strength - muscular power, all that sort of thing. All they've got to do with children is to mind them a couple of days a week but um, feel vulnerable when in pain and therefore that vulnerability can be exacerbated by the fact that they are feeling pain, feeling why should I feel that - why me when I'm so strong, I am a man and the doubt and vulnerability goes on for a while. Conversely you could get someone who doesn't feel that at all... I was thinking about the reactions of a girl child and a boy child to blood, as a result of a cut and I would generally imagine that the girl it would be "Oh, I'm bleeding" but the macho act of the young boy would be "I've got a cut but I'm all right - I've got a plaster, look at my scar". Not that I don't think that girls could act like that but the conditioning of boys to be macho is very strong...' M8

'In your childhood you're not brought up in a vacuum, like you see in problem pages in women's magazines, letters from mothers - "I'm worried about my son, he's timid, he likes cooking and things - is he gay?" In other words you're only allowed to be sincere and sensitive if you admit to being gay, being like a woman. In this society, even men who are aware of it and don't like it, have to obey the rules - it's so drilled into you from childhood, you just can't escape it - to admit to being as sensitive as a woman, it's very difficult to overcome those social barriers. The more



artistic- artists are allowed to be expressive, sensitive whereas scientific people have to be rational and sensible all the time. It is odd to see a man cry. I don't think there's anything bad about it, it's just that it's so rare. Maybe if a woman was brought up in the same way - you mustn't cry, go and play football instead... women themselves, even the most feministic, still go sort of helpless - oh please - sidle up and get what they want - I'm sure that happens to the best of us.' F6

The negative effects of this conditioning are perceived by both men and women in this sample:

'When I was working as a midwife we always reckoned that if it was men who had the babies the birthrate would drop in negative proportions!

Q: So why do you think women do cope better?

Well, we're brought up that way - a lot of that is nature/nurture sort of stuff but at the same time we're brought up to be allowed to express it - big boys don't cry and all that sort of thing whereas girls are allowed to cry, they are allowed to express their pain - it's probably just as well because I think women do go through much more pain - emotionally - they're more likely to address it and deal with it rather than- men are more likely to repress it and it comes out in aggression...

Q: What do you mean by the nature/nurture stuff?

Well it starts at Day 1 really... there are very clear differences in the way that boys and girls behave and develop but what is often superimposed upon that is what is acceptable and what isn't acceptable. I've never had a child so I don't have first hand experience but the children I've been around - the damage that parents can do to kids, telling them that they cannot, will not behave in a certain way - it's enormous. Well, it's partly parents and partly peer pressure but I really don't know - I think they definitely develop differently. Yet you see men, when faced with severe pain go totally to pieces in a way that women don't, usually. But it seems that women are much more stoical about things like dysmenorrhoea than a man would be experiencing the same kind of pain...' F10

'Well because women are more down to earth individuals and grin and bear it - if they have something wrong with them they either try to get the doctor to sort it out for them or they try to snap out of it themselves.' F2

### **Expressing pain: benefits and costs**

In attempting to make generalisations, the patterning of pain coping by gender can be seen as ambiguous and as ambivalent:

'Women are more prone to depressions, they're more prone to things sort of swamping over them, they indulge in it, stay at home all day and eat - um let me think, well men get looked after by their women-folk. Women have to sort of strive and get on with it, whatever whereas men can indulge themselves more. Women are actually stronger, they don't have illnesses so much... When you think of individuals, I've got an aunt who whinges about the slightest pain, she's in pain all the time. It sort of goes this way and that. You get the sense of thinking that men will try and battle it out and don't take a painkiller at the first sign whereas women will. On the flip side of that women are more practical, they won't accept pain - it goes this way and that. If a woman's got pain and lots of kids she has to hang on and look after them. As a boy I was always told that the good Indian suffers in quiet.' M2

The perceived superiority of capacities of endurance is double-edged for women - the assumption that they may be able to 'cope' better may lead to the expectation that they can put up with more pain, that their pain does not need to be taken so seriously:

'It's easier to be a man but maybe that's because I am a man and that's the way I've been led to think. I can only see it personally like the world according to - sort of thing. I do think the one thing with pain, when it's your mum or whatever you do find yourself thinking she can cope with it. The impression that I get is that women aren't supposed to feel pain. Now I would but as a kid I never felt any sympathy whatsoever, I didn't really understand...' M1

'I think from my experience both being a nurse and a patient, doctors are much more likely to tell men what's going on, what's involved, especially when it's something surgical when it may be related to the workings of the combustion engine whereas they will assume that women are ignorant about the functioning of their body. Also often they don't relate very well to women, if you've got male/female, lay person/doctor and very often a class difference as well, and really being able to communicate with a female patient who maybe hasn't had a lot of education they find very difficult and they assume a lack of education much more. The trouble is that women doctors do the same... at one point I asked the consultant orthopaedic surgeon, when the bone in the leg wasn't healing and I asked him what sort of approaches he was going to take, like was he going to a bone graft, was he going to a plate- what was the range of possibilities. I wasn't asking him to decide then and there, I just wanted to know the range of possibilities I should be prepared for when I woke up and he turned round to me and said "I'm not in the habit of discussing these things with patients" and I was furious...' F10

'Well, I've never seen it in terms of being female but when I first developed the symptoms of what turned out later to be the brain tumour, for 2 years every doctor I went to told me I was depressed. And of course it's hard to know whether illness, pain whatever makes you depressed or if it's the other way round. And of course there were other things going on in my life which made me - if not clinically depressed well certainly down, like problems with my career, breaking up with a boyfriend, you know things like that affect everyone. But my mother always said she knew it couldn't be depression because I was doing things that wouldn't indicate that - like planting the garden, little things maybe but which were important. But if I hadn't persevered, and my mother backed me up it may never have been diagnosed...' F1

Being taken seriously was not perceived as just a gender issue, and other respondents felt that the colour of their skin or being working-class meant they were either ignored or not given information.

'I think there's a big ethnocentric thing about pain as well. I know that people would say, and supposedly quite astute intellectuals that - it's not just a racist thing but that women in Victorian times were used to their offspring dying - that because infant mortality rates were high that it wasn't that painful and I hear the same arguments about the families in India - that women there would be used to it and I think that's absolute shit because it demeans the whole relationship of one human being to another.' M8

'I'm very working-class in my relationship to doctors - I'm beholden to them - I don't trust them and I do a lot of exploration of myself. God knows what would happen if I were really ill because I think the service we're retaining now in the NHS isn't good enough. Back in the 60's my husband's mother, one the first wave of black women from the West Indies - she complained of pain - she was ignored and ended up having cancer of the ovaries and she died... OK, everyone's got their own collection of horror tales but there are too many of them - from people I know and in my working life - to just dismiss it. I think accessibility to health care is becoming more and more dependent on money - if you've got the money you can 'buy off' the pain to the extent of the information you obtain and the quality of service you receive.' F8

The notion that aging implies an increased expectation of having to endure physical pain through illness was also strongly held. The implication is that the lower down in the social hierarchy the person is, the more likely they are to experience discrimination with pain, as in other areas of health and illness:

'Yes, women cope better with pain but should they have to? The we're here to suffer - type - thing... The collection of women I've seen suffering in my lifetime is enormous - maybe my eyes are attuned to women - much more enormous than the pain I've seen men suffer. I've seen women, black women particularly, and white woman too, in enormous amounts of pain and just living with it.. 'F8

## Conclusion

Perceptions of pain-coping abilities are strongly gendered. In the interviews women are seen to have superior pain-coping capacities, and this is explained in highly sophisticated terms underpinned with biological principles, but embracing socio-cultural themes of roles and socialisation. Female hormonal and reproductive functioning and the role of motherhood were consistently felt to equip girls and women with a 'natural' capacity to endure pain, whereas for men pain was conceived of as 'abnormal', and outside their 'natural' expectations and experience. The assumption of women's superior pain-coping capacity may be double-edged, in that the expectation of being able to cope can lead women to ignore pain. Similar notions are, however, expressed in terms of race, class and age, and would seem therefore to be a function of social minority group status. This would suggest that to be disadvantaged in the wider social structure has implications for any understanding of the perception of pain.

The next chapter presents two case studies, which combine material from all three methodological approaches in order to illustrate how the social circumstances of the individual shape and inform their beliefs about health and illness, and in particular their perceptions of pain in relation to themselves and others.

## **CHAPTER 9.**

### **COMBINING METHODS: CASE STUDIES.**

These case studies are composed by bringing together data from all three approaches - the questionnaire, the interview and the responses to the images - in order to form a coherent picture of the respondent. Whereas the questionnaire provides an outline, the 'bare bones' of individuals, their social circumstances and their beliefs and attitudes, the interview and imagery responses act to 'flesh out' this framework and provide insights into their lives. Used in this way, the data demonstrate vividly how the social fabric and characteristics of peoples' lives moulds and shapes their beliefs and perceptions.

#### **CASE STUDY 1: SEAN**

##### **Questionnaire responses:**

**SEX:** Male

**AGE:** 28

**ETHNICITY:** Father Irish Catholic; Mother English Catholic, Maternal grandmother English Jewish.

**OCCUPATION:** Double glazing salesman (full-time).

**TENURE:** Lives with family in parents' own home

**EDUCATION:** Left school aged 16, no formal qualifications

##### **HEALTH STATUS:**

#### **1. LONG-TERM ILLNESS/DISABILITY**

For last 15 years, has had an endocrinal disorder involving hormone deficiency. Began out-patient treatment 8 years ago receiving regular injections and G.P.treatment. States the effect upon everyday life is "total" and is not satisfied with treatment he receives:

'Most definitely not for a number of different reasons I decline to go into, but I am very bitter and feel I would like my revenge but I don't know against who or what'.

## **2. REASONS FOR VISITING GP/LAST SHORT-TERM ILLNESS**

Influenza virus less than 6 months ago treated with antibiotics

and medication from chemist.

## **3. ASSESSMENT OF OWN HEALTH**

OVER LAST YEAR: Good.

OVERALL HEALTH: Fairly unhealthy.

## **4. HEALTH BELIEFS**

### **GOOD INFLUENCES:**

'Plenty of money and work, good relationships, total control over my own life and possibly some control over other people's lives.'

### **BAD INFLUENCES:**

'Boredom, jealousy, poor housing, being forced to share what I'd rather keep to myself, not getting my revenge, continuous medical treatment but most of all being envious of someone or something.'

## **5. PAINFUL EXPERIENCES**

INJECTION PAIN SCALE (1-6): 1

WORST PAIN SCALE (1-6): 5

WORST PAIN: Beaten regularly as a child, unable to seek help.

## **6. EMOTION AND PAIN**

Thinks that effect of anxiety, depression and fear on pain perception is 'a great deal'.

## **7. GENDER AND PAIN**

There are no differences in abilities of men and women to cope with pain - 'I think it all depends on the bad luck and fate of the individual'.

## **8. CURRENT PAIN**

Yes, caused by 'bad luck and bad feet', seeking treatment from G.P., chemist and chiropodist which is satisfactory.

## 9. OTHER IMPORTANT FACTORS

'I can only stress that my problems have been caused because I am a cross-breed. I am in no way racist or prejudiced and I do not mean any offence to anyone. I blame my problems on the fact that I am not of one nationality and I feel all people should be - my views are directed at a person's blood and not at the colour of their skin. I am white skinned but I feel all men and women-black, white, yellow are good as long as they are full-breeds. I add I feel more mental pain than physical. I would help anyone if I could and I like to give the impression that I'm very happy when really I'm not.'

## INTERVIEW RESPONSES

### 1. CONCEPTS OF PAIN

Sean talked at great length about painful experiences he could remember from his childhood, which included being run over by a car. The worst memory, however, was of being beaten with a belt by his father for wetting the bed:

'My dad, he never gave much to me. He didn't give us a hiding just for no reason but, not like some people do, but for wetting the bed, anything like that he used to give it with a strap and get my face rubbed in it, all that-well that would be the worst thing, you know, and not having things other kids have - even now I'm very bitter about it but I don't show it, you know, to other people. I get very depressed, not just about that but for other reasons, other people don't know because I don't show it, I hide it but it's there all the time.'

This had happened recurrently throughout his childhood and he expressed a great deal of bitterness and resentment against his father throughout the interview. He considered himself to be in 'mental' pain all the time, which in his view was much worse than any physical suffering he could imagine. He felt that life had treated him very unfairly.

'Yes, like if you're a kid and you have an accident, the sympathy is there afterwards, like with stitches in your head and people giving you sweets, you're sort of like a celebrity at school, it's like being famous. Although the pain part of it wasn't very nice afterwards was good. But what came after wetting the bed, its just more- you've done it again, the humiliation, not just being beaten..'

He found it embarrassing to discuss his hormonal disorder, which he does not know the name of, and reflects it has always made him feel 'odd' and marginalised. He described

the humiliation that this caused him as an adolescent as many of the normal pubescent changes did not occur, such as his voice breaking. He did not seek or receive treatment for this condition until the age of 21. Until this time Sean maintains he just ignored the condition and claims that he only received treatment because his elder sister insisted that something should be done, as Sean was incessantly being teased by her boyfriend for being a 'poof' or a woman.

In the open-ended section of the questionnaire (see section 9 above), Sean had expressed beliefs about race and nationality in relation to perceptions of pain. These were elaborated upon as the interview progressed, and it became clear that he had built up an extremely complex belief system, involving his parents and their ethnicity, to explain his suffering:

'I feel that all the pain I've suffered comes back to the fact that basically I'm a cross-breed, I don't mean in terms of colour but I'm meant to be Irish but I'm not really, not pure... I suppose I'm the only one in the family that feels that - I've said it to them, I've even said to my mum - she didn't like it but she's had a lot of problems and I said to her one day that it's all to do with the Jews. My mum's real mother died when my mum was only 17, she was Jewish - the grandad's been married twice since, he's still alive and in good health but she died of cancer and I said to my mum one day, the reason you're having problems with your legs and your knees now is because of the Jews, because of the curse upon them - because going back to religion again, because they crucified Christ. But if I said that to a Jewish person they'd take offence and I don't mean to offend them, I'm not anti- Jewish but I think a Jew should be a Jew and a Catholic - well that's just religion... but people should be what they are, there's no sense of identity any more, like patriotism is a dirty word. I think people should be given back a sense of identity as something to even fight for if it came to it but there's nothing... at times it really bothers me, at others it don't. When I say to people, I blame the Jews I don't mean to er... I think it's a curse that follows people around and now I think it's following me and I blame a lot of the problems that I have - but you've got to be careful what you say to people and sometimes you bottle things up rather than say it.'



## 2. RESPONSES TO VISUAL IMAGERY

(see Fig 4:1 and Chapter 7 for reprographics of imagery).

Sean enjoyed using the imagery very much and gave very detailed imaginative responses, incorporating comparisons with fiction, popular films and TV programmes:

### PAIR 1

'They don't seem to be in physical pain there, seems to be mental pain. She's sort of err, that one there [A] that seems to be in bed and the other one holding her hand or something, maybe she's dying - looks like an old sort of Victorian thing. And that one there looks like [B] well there's bread on the table which she, that would make me think well they've got no money, just a bit of bread to eat, don't know what upset her, perhaps her husband ran off or something - it's got that sort of look about it. It seems to be more like she's being comforted, like somebody's upset her - it doesn't look like any physical pain, must be mental for both of them - well she might be suffering physically cos she's giving sympathy. By the look of the picture it looks from out of a Charles Dickens, it's got that sort of a look about it, that's what gives me the impression that she's dying but the face is not that clear- she seems to be, or is it a he, I can't make it out, praying for them more or less with her head bowed, they're not looking them in the face and that one there, the old one seems like she's trying to comfort the young one. I think err, it's hard to say what's happening but judging by the state of the house, there's poverty, they haven't got any money and maybe the husband ran off and left her, I don't know. That one would make me feel well, I'm glad I wasn't around in them times [B] - I often feel like that when I see these old programmes because however bad things are now they'll never be as bad as they are then, in the Victorian era but then I don't know actually - I feel sympathy for them but it's like pain that's past - it's hard to feel sorrow for someone suffering when that suffering is past. If they're suffering now you can feel it for them but when they're - like her in the bed [A], she's better off dead, like if she's got cancer or whatever she's better off dying than lingering on. In them days life expectancy wasn't so high - people had large families and lots of kids but only two or three of them would survive...

Q. Who's suffering the most?

Well, physically her [A] and mentally her [B] because she's giving the impression that if it is old times, then maybe the diet or health isn't very good but she's only contracted what she's got in the last couple of years - maybe cancer or TB or typhoid or whatever it is they catch, she's only had it in the past couple of years but she looks like she's had a hard life all along and whatever she's got left she's still going to have it so.. pain, actual pain she seems to be suffering worst but she seems to have broken down, she seems to have broken down - they seem to have got me, the bastards, there's nothing I can do about it - it's funny really....'

**PAIR 2**

'Well she looks like she's pleading for a bowl of rice or something, almost like those jokes about the famine, I remember as a kid about Biafra - the Biafran cookbooks type of thing - as a kid you didn't really understand it but you still tended to make those kind of jokes as you got older. She seems to be begging for mercy of some sort and the one in the background there seems to be half sort of smiling - maybe it's the way the camera's caught her... and he's sitting down, looks like he's lost something, like his wife's died, he's got that sort of I'm on my own look - like he don't know where to turn for help or he don't want any help... she looks like she's begging for something, mercy or food but maybe he's begging too. Maybe she's asking God for help and he's saying look, you've let me down..

**Q.** How does it make you feel?

It makes me feel I'm glad I'm not her, maybe I shouldn't say that but I'm glad I don't live in that society because they're still suffering in the way of those pictures a hundred years before. It makes me feel like there's two old people from two different backgrounds, that maybe he's had a good life, maybe been through a couple of World wars, he's had a hard life but maybe a good life whereas her... it's much more recent, maybe the 70's, but she's had to struggle all along. You'd have to know really what background they had - it makes me feel pity really although that one in the background seems to sort of be smiling - maybe it's a hanging or something and they're all flocking to watch... where he could have been in an accident or something but it's hard to know, but the feeling is pity and it's more for her...'

**PAIR 3**

'I can't make out what that is - oh there's a face there. That would make me think of one of them funny artists, like that don't make sense, well it's the sort of picture that makes you think about it rather than you can just look at. Like that picture where she's in a boat, or a gondola whatever it is whereas he - I think it's a he - the man in black, it's very mysterious, it doesn't tell you a lot. It's hard to see - this tells you what it is - she's out on a lake enjoying herself but that doesn't tell you a lot at all, it makes you think, well what is it? She - the hippy, I'd have to say, by the look about her, she's got that "Let's go to San Francisco" look about her or Woodstock or with those candles and that boat and that it could be a hell of a lot older, a photo of a painting rather than a photograph, judging from what's woven on the blanket, it could be a knight in armour or something so looking at it more closer, it could be a Maid Marion sort of thing, or Knights of the Round table - Guinivere waiting for Lancelot to come and save her .... Whereas this - he's got that Paul McCartney sort of look, sitting at the piano creating sort of thing...

**Q.** Do either of them suggest pain to you?

No, more of the man - he's sitting there thinking well what sort of song shall I write next, sort of well I'm tired and she looks like... boredom. Are they supposed to be pain?

Q. Not necessarily, there's no right or wrong answer, it's just what they suggest to you.. so you wouldn't say one of them was suffering more than another?

No, if anything him, the way she's dressed, she's got money, she had a good life anyway, it doesn't look like she's got any problems.'

#### PAIR 4

'Oh Christ, well she looks like she's gone a bit far with acupuncture there ... Both of them give the impression they've been tortured, he's got that sort of biblical thing, although judging by the style of the arrows and that it's not quite that, he's got that Jesus look about it if you know what I mean, he's got like a loincloth or whatever, whereas she, I would say by the look of what she's had done, she's been accused of witchcraft or something like the Spanish Inquisition judging by what she's made to wear there. She's been tortured into confessing something like witchcraft and he looks like - he's obviously been tied up to be killed but he's obviously been humiliated first - there's one through his leg and one through his arm so they've obviously made him suffer that pain first and that one in the stomach would make him suffer whereas this one is aimed right at the heart - it looks like he's been made to suffer, the two of them have but she probably suffered the worst - with all them pins and that she's obviously been made to feel terrible pain - some of the things they did to people, I've read up on it. Some of these things make you think what Nazis and that would have done to people or the Spanish Inquisition or the witch-hunting that went on through the Middle Ages. So she reminds me more of some evil while this one - maybe he's said something to upset someone like a Jehovah's witness or a bit of a preacher, it's obviously very old, Roman sort of Jesus type thing about it, you know what I mean whereas this one is a sort of Joan of Arc look about it...

Q. What do they make you feel?

I find myself, more how could they do that to people... she's suffered more-whether that really happened or whether it's just trying to show in those times, I don't know...'

#### PAIR 5

'Well, they're crying - it's hard to say with a child, [A] he looks in more pain - makes me think of the Nelson Mandela thing where you see these blacks being beaten to death and it looks like a Soweto type of thing, his father's been killed and he's just been oppressed. [B] He looks more like-it's hard to say really, he doesn't look like he's suffered at all, he might be crying because he's not allowed an ice-cream. Kids can react to things in

different ways - it doesn't seem to be by looking at his face and hair and things like that he's suffered mental pain like his mother dying or things like that but there's something about the look of him, he just looks you know the way he'd be if you wouldn't let him go out to play or something like that or maybe somebody hit him but he seems by the look of sorrow in his face, and anger, by the way his face is twisted, he's really suffering, he's the obvious one there. But he does seem to have someone with their arm around him comforting him, by the look of things and the style of dress, the jumper, if you see them newsreel things they seem to be wearing that type of clothing in Soweto so I would say that he's suffered more there. Mentally the other one's suffered maybe... It makes me think Thank god I'm not black and I'm not living in South Africa, although maybe that's not South Africa at all and him, I feel sorry for him although somehow I feel he hasn't had a bad life at all - I can't really feel pity for him because I can't see in his face what's wrong... he's got a what-did-I-ever-do sort of look in his face, why me? - it doesn't really affect me, he's just been told off whereas him, you can tell he feels real pain - the two are very different.'

#### PAIR 6

'Bloody hell, that's one way of getting rid of the husband isn't it? Well this one, makes me think of those sort of films - I don't particularly like them-like Friday the 13th or Nightmare on Elm Street - you seen any of them? No? Well this probably some sort of devilish thing, something very unholy and evil- you can see someone's had their head ripped off - that sort of thing makes me think at times I wonder what sort of mind people have got to - er dream that sort of thing up - there's two bodies, there's another one lying there. It gives the impression someone's fed them to these beasts or whatever they are whereas this one - they've cut his throat and the blood is spurting out, they've come in and surprised him when he's been sleeping, it's got a French Revolutionary sort of look about it. They seem to be dressed fairly well, she's got jewellery on and that where she looks more like a maid, that one.. For this one, I feel that could be me, it could happen to anyone but this sort of thing doesn't seem real, it's more like Spielberg or something, I don't identify with that because I don't like that sort of film, I don't like people getting killed, I don't like those pictures, it doesn't do anything for me at all but that one I don't see as being real, it's more been created for the camera or the painting. This one I can familiarise with that more because that is real, has gone on, did go on and still goes on now - it looks like he's been asleep and they've come in and caught him by surprise, by the time he's realised what's happened it's too late he can't do nothing to save himself, so I feel more pity for him, you know, make sure you lock the kitchen up... They could have killed him for a number of reasons, judging by the look on their faces it could have been mother and daughter, he could have been a murderer or a rapist, anything like that. I've no idea, he's obviously done something wrong or he's a tyrant of some sort because it's unlikely that they just went in and did that for the fun of it. They've done him with his own sword. Judging by the time it's

further back than French Revolutionary by the style of the sword. He's been caught, he's woken up like and it's too late to do anything about it whereas this one is just like - heads lying there, it's just a painting, it's like all those films of people getting their heads cut off, like Aliens, I think that's a bit sick really....'

Image Choices

Most Pain 4 B

Identify 3 B

### 3. PAIN AND GENDER

Sean could not remember what he had originally said in the questionnaire but when asked in the interview, he thought that women were more likely to cope better:

'But I think that women cope better or have to cope better, I don't say they do but I think they have to because a man can go off to bed if he's feeling well but a woman has still got the kids there or they're not really allowed to be ill- they don't think, she still has to get the jobs done - the kids are screaming for attention they don't really understand that Mum's not well 'cos if Dad's not well he'd be in bed.. so I'd have to say that possibly it's worse for a woman, physically and mentally probably because they're not allowed to show it. Mind you a man could show his feelings but he just doesn't... especially with kids it's just sort of all the running about, except in a few cases the odd case here and there. The man only has to provide the earnings, well in a lot of cases the woman has to provide money too... so women suffer more - it's a man's world really in that respect.'

Although he thought there were individual differences, on the whole women would be more "sensible" and seek help quicker; men would be less likely to accept that something was wrong with them. He also felt strongly that boys were "brainwashed" into not being allowed to show their feelings, especially when feeling hurt - in the home, at school, by television. But on the whole he considered that men's lives were easier than women's. Despite the fact that Sean perceived himself as unlucky and something of a misfit, he gave a very lively animated interview peppered with jokes.

## **METHODOLOGICAL COMMENTS**

This case study clearly demonstrates one of the aims of the interview, which was to 'broaden out' definitions of pain and explore links between physical and emotional concepts. Sean had begun to make these distinctions in the questionnaire and to outline beliefs that he thought relevant to perceiving pain. The less formal and constrained nature of the interview made it possible to develop and explore these themes. Sean was able to express highly complex and abstract belief patterns incorporating social characteristics such as race and class, as well as existential notions of fate and destiny. His responses to the visual imagery developed these ideas further as many of his interpretations of the pictures referred to aspects of his own life and predicaments.

A discrepancy between the questionnaire and interview was Sean's response to the question of the abilities of men and women to cope with pain, which, as with other respondents, changed completely.

## **CASE STUDY 2: ANGELA**

### **Questionnaire responses:**

**SEX:** Female

**AGE:** 36

**ETHNICITY:** Black british: Father, Caribbean; Mother, Irish.

**OCCUPATION:** Residential social worker in community mental health.

**TENURE AND HOUSEHOLD:** Shares a privately rented flat with husband, his teenage child and her sister.

**EDUCATION:** Left school aged 18, educated to higher degree level.

**HEALTH STATUS:**

## **1. LONG-TERM ILLNESS/DISABILITY**

Describes as 'a long-term tendency to worry - my mother died at 37- worry the same thing will happen to me', which has affected her for over ten years and, she feels, has a substantial effect on her day to day life. She has been receiving psychotherapy for the last four years and has daily support from her husband and sister. She thinks the support she receives is satisfactory.

'I'm not clinically depressed but I do worry, and despite outside appearances, I carry an awful lot of stress at work and at home.'

## **2. REASON FOR VISITING GP/ LAST SHORT-TERM ILLNESS**

Influenza and exhaustion over the last month which is still lingering:

'I never got to the bottom of why I was feeling so unwell, re the GP. I wanted to tell him how completely rundown I felt but couldn't the first time. I'm on a second visit, maybe I'll pick up courage today.'

## **3. ASSESSMENT OF OWN HEALTH**

OVER LAST YEAR: Fair  
OVERALL HEALTH: Fairly unhealthy.

## **4. HEALTH BELIEFS**

GOOD INFLUENCES: 'Good relationships especially covering work, husband, child, sister and friends. Feeling valued, feeling relaxed - living for the moment. Control and feeling hopeful, not hopeless. Feeling I'm getting somewhere with my clients at work, that they are developing.'

BAD INFLUENCES: 'Overwork. Feeling responsible for work, family, husband, child, feeling overburdened (which I am). I smoke like a chimney, overeat and feel quite helpless sometimes. My housing situation, recent traumas cause worry; the constant pressures as a black working-class woman bring me down.'

## **5. PAINFUL EXPERIENCES**

INJECTION PAIN SCALE (1-6): 2  
WORST PAIN SCALE (1-6): 3

WORST PAIN: Mother dying, had help and support from friends but has never recovered completely.

## **6. EMOTION AND PAIN**

Thinks that effect of anxiety, depression and fear on pain perception is 'a great deal'.

## **7. GENDER AND PAIN**

Angela thinks that women are able to endure more pain than men:

'They have to - no choice '.

## **8. CURRENT PAIN**

Yes, not physically but from 'total life pressures'; seeking help from GP, family and friends.

## **9. OTHER IMPORTANT FACTORS**

'Being "ill" is a very personal experience. People feel ill differently - people's distress threshold is different. I feel distress/bad housing/oppression/no hope/are all linked with illness. Illness equals for me fear/helplessness/fear of dying and all sorts of irrationalities. I smoke/overeat - knowing all these things are bad for me - I don't stop.'

## **INTERVIEW RESPONSES**

Angela arranged for me to interview her at her office, in a psychiatric hostel in West London, as she claimed it would be more difficult to talk at home, due to the lack of space.

### **1. CONCEPTS OF PAIN**

When I initially contacted Angela, she was very keen to do the interview and emphasised how the questionnaire had been very topical for her. She had completed it whilst waiting to see the doctor and she had originally intended to present with 'physical' complaints such as 'feeling run down' but was spurred by it into talking about the pressures in her life. As she had indicated in the questionnaire, these were especially stressful as she was still experiencing the bereavement of her mother, who had died six months earlier. She felt that it was undoubtedly the most painful aspect of her life. Angela had obviously



given the topic of pain much thought, especially the psychological and emotional elements:

'I'm guessing as it was a long time ago but I think the worst pain for me would be an emotional pain which for me is as valid as other types of pain- I always feel that physical pain somehow gets the attention - I'm not saying the two aren't related but for me I think the most painful experience if you qualify pain, emotional or physical, was when my mother died and I'm still not over that. Well you see I've not suffered physically that much - I don't even know if I'd say I'd suffered emotionally, I mean life is incredibly painful, it's perverse in a way. In my work if people come to me in pain there's something - there's something pure about pain, when people are going through pain it's instantly recognisable. And when your'e going through it yourself, for me there's no ambiguity - I'm feeling pain. I'm sure it's got a certain power and currency but I wouldn't want to glamorise it because I think life and living should be as pain-free as possible because pain scars both emotionally and physically.'

These themes were woven through her working life, as she was concerned with rehabilitation of the mentally ill and felt strongly that illness or disorders of a psychological or emotional nature were not given as much credibility as those with a demonstrable pathology:

'I hate the hierarchy of pain where one pain will be treated with a sincerity and seriousness and other pains are vindicated as not being important, so I'm not sure on that one. I do think though I've got no evidence for it really, it's a lot to do with culture and what's allowed to be expressed when and where, what's socially acceptable, and in my experience, mental illness is bottom of the pile.'

Although Angela was educated to higher degree level and was working as a qualified social worker, she regarded herself as 'working class' and felt that a person's class position was an important factor, as it would influence the amount of information and knowledge received and given:

'I do think that education must be part of it but - I've got a funny thing about that - I've read theories and somebody here pointed out that with the class thing and with pain - for middle-class people - whatever that means, the pain of mental health can be greater because it can't be assuaged by promises of fridges or a house - these people may have that anyway and they're still in pain. I didn't like the argument at all because

for me working in East Acton, a very working class, impoverished area, I even think in the type of medical care you get depends on the class position but is mainly directed to how much you can afford to spend on yourself. Especially these days in Thatcher's Britain I think accessibility to health care is becoming more and more dependent on money - if you've got the money you can 'buy off' the pain to the extent of the information you obtain and the quality of service you receive. But I'm very working-class with my relationship to doctors, I feel beholden to them - I don't trust them and I do a lot of exploration of myself. God knows what would happen if I were really ill because I think the service we're retaining now in the NHS isn't good enough.'

Angela also felt there were implications for the type of treatment given as regards ethnicity:

"Back in the 60s my husband's mother, who'd just come here from Jamaica complained of pain - she was ignored and ended up having cancer of the ovaries and she died... OK, that's just one story of one black woman but everyone's got their own collection of horror tales but there are too many of them - from people I know and in my working life - to just dismiss it. I do worry that if anything were seriously wrong with me, which is a fantasy I carry around with me a lot, especially with my own mother dying when she was 37 and it's my 37th year - she had no warning signs of pain and just died - so it's an interesting one with me.'

Obviously, for Angela the role of gender is inextricable from class and ethnicity. She also thought that the questionnaire and interview should also encompass the role of religion. Even if a person did not see themselves as practising or believing in religion, as a lapsed Catholic, she felt that the effects were still pervasive with regard to beliefs about pain.

## **2. RESPONSES TO VISUAL IMAGERY.**

'...this isn't on a scale is it?'

### **PAIR 1**

'[B] The whole scenario is just so bleak and despairing - neither of these women can give each other hope it seems and the one on the floor is absolutely overcome with suffering but... in my imagination, my fantasy it's something to do with emotional pain there. [A] - I've got a fantasy already about it - a daughter and a mother. The mother seems more affected than the girl or young woman with her. I think for me the one [B] is less hopeful, the way it's drawn, the colours used.. but [A] is more shocking, it's really about pain, I don't know who's reassuring who there, who the brave one is.'

**PAIR 2**

'The man is in anguish, what he's going through is certainly not pleasant but it's a personal anguish whereas the woman - it's more shocking and it upsets me far more. I don't know if it's because it's a photograph but I don't know what sort of pain - it could be death, loss, torture, something happening in the body but it's not personal. Both represent very different things.'

**PAIR 3**

'[A] Well that's a pre-Raphaelite, sort of morbid, Arthurian - she must be pretty used to the pain level with everything that happened to women in those times. [B] This is all about loss and everything associated with it but neither of these move me very much, not like the ones before. There's nothing I relate to personally in them.'

**PAIR 4**

'[A] I don't know if that's pain, it's almost sexual, it's about something else.. he's too prettily poised... As for her, she's not a real woman, it's an image of a woman and although I should be terribly... it disturbs me more but it's very hard to say because if she gets some sort of kick sticking drawing pins into herself then it's not necessarily more painful than having arrows stuck into you. It's somehow deliberately - well both of them are pictures of deliberately inflicted physical pain, either by somebody else or by themselves. Maybe neither of them are about pain, they are symbols of something else, something sort of sadistic. I find them a real turn-off, I don't understand them, they don't play a part in any part of my life or of my relationships.'

**PAIR 5**

'The black child on the left is in far more pain, he's in agony and it raises all sorts of personal unbearable issues for me because he's black and I can remember all the teasing from when I was a kid... whereas the child on the right is sort of dazed. He could have had something just as bad happen, they're both equally as sad but the black child has more pain.'

**PAIR 6**

'This one on the right, it's about far more than pain, he's actually facing death. It's hard to sort out - I mean he may have done something really terrible - maybe he has hurt these women - it could be a mother and daughter and he's raped the younger one. Now they're getting their revenge. It's hard to feel any pity if that's the case and yet... "Thou shalt not kill". I can never completely get rid of Catholicism... The one on the right is pure fantasy, it's just not real.'

Most Pain 1B & 2A  
Identify 4B

### 3. PAIN AND GENDER

Angela continued to express the same viewpoint as in the questionnaire, namely that women are able to endure more pain than men. She thought that the socialisation of men and boys makes the expression of pain more difficult for them but that generally, they receive better 'service'. She believed very strongly that this superior coping ability is double-edged, and arises through the position of women in the social hierarchy, cross-cut by other characteristics, especially their ethnicity and social class:

'Yes, women cope better with pain but should they have to? I mean I don't know where that's come from. I mean my grandmother who's Irish, she belonged to a different generation and she'd cope with enormous amounts of pain, I mean physically and her religion - somehow the pain was awful but it was good as well - we were here to suffer. My mother coped with a lot of emotional pain, an awful lot, had no-one. Before the term single parent came out she was a single parent and seeing her in pain was difficult, I can't really remember it now but the collection of women I've seen suffering in my lifetime is enormous - maybe my eyes are attuned to women - much more enormous than the pain I've seen men suffer. I've seen women, black women particularly, and white woman too, in enormous amounts of pain and just living with it. I've got a friend who's a midwife at St George's and she was working with a Somalian woman and she was terrified to shout out in labour - it would be a disclaimer of her womanhood to actually give into the pain - totally reinforced by the husband. But I'm not saying that's just particular to Somalis or black people because I know in a lot of working class, traditionally European or Irish/English places, women don't say they're in pain - I'm not like that!'

### METHODOLOGICAL COMMENTS

In common with the previous one, this case study illustrates how the themes which can only be touched on in the questionnaire, and then through open-ended questions, are broadened out and expanded upon. For Angela, the complex nature of pain involves many facets, including religion and culture and she places great emphasis on social characteristics. In contrast to Sean, Angela did not deviate from any of her original responses on the questionnaire, but developed them much more fully, particularly her beliefs around gender, race and class. Personal experiences of these issues in her private

and working life permeated her responses to the imagery.

The case studies demonstrate how both the quantitative and qualitative approaches can be blended to produce a comprehensive and detailed portrait of the respondent and of the characteristics and experiences in their lives which affect their perceptions and beliefs.

## CHAPTER 10

### CONCLUSIONS.

'Pain is not for no reason - it's part of a natural course of events - if you don't understand how to live your life there will be pain if you do it wrongly - a kind of punishment. Just as the mind and feelings can affect the body - like anxiety so the sort of body you've got affects the emotions, so it's both...'Interview respondent F5

'English, which can express the thoughts of Hamlet and the tragedy of Lear has no words for the shiver or the headache... the merest schoolgirl when she falls in love has Shakespeare or Keats to speak her mind for her but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry' (Woolf 1967:17).

In this final chapter, a summary of the research design and findings is presented, and the contribution of the research is evaluated within a context which takes account of its potential theoretical, methodological, social, and policy and practice implications. Broadly, it is argued that exploring and understanding the relations between the 'nature' and 'culture' of pain, on the one hand, and the social construction of gender on the other, can inform a range of other understandings, including those related to health, illness, normalcy, theories of embodiment, knowledge, science and power. Understanding the relations between pain perceptions and gender also throws light on medical theory and practice, and beyond this more generally on the 'set' of cultural values concerning 'man' and the environment.

#### **Aims and methods**

The aim of this research was to initiate an exploratory phenomenological approach to the perception of pain, with a focus on the role of gender in the formation of pain beliefs. The theoretical background drawn upon is the sociology of health and illness, and particularly the literature on gender differences in mortality, morbidity and health service use. A substantial number of unsolved questions are raised in these areas both in relation

to the ways in which experiences relating to pain are gender-differentiated, and the explanations for any such differences. As the sociological literature on pain is very sparse, a variety of psychological, medical, philosophical and anthropological sources have also been considered.

The fieldwork for the research took part in two stages. The sample was obtained via a general practice surgery in an inner-city area of North London which has a very mixed social profile. Data collection took place over a period of nine months in 1989 and 1990. Using the principles of triangulation, a questionnaire was designed to attempt to examine the beliefs about health, illness and pain of a wider population, to collect social, demographic and medical information and to engender themes which would be examined in more depth by an interview sub-sample. The questionnaire was administered in a G.P. surgery and was completed by 107 men and women. In the second stage of fieldwork a more qualitative approach was adopted and a sub-sample of 21 people took part in the in-depth interviews, which explored the complexities of attitudes and beliefs about the nature of pain, both from personal experience and through responses to the predicaments of others presented by a series of visual images. Key questions in both instruments addressed general health beliefs, experiences of illness and pain, the role of emotions in pain perception, the perceived ability of men and women to cope with pain, and the importance (or not) of other variables such as race and class in shaping pain experiences. The research questions were not confined to chronic pain, encompassing any experience the subjects themselves defined as pain, either in the past or in the present.

### **Summary of findings**

The findings of the study both reflect the particular experiences of people living in a multi-racial inner-city area, and provide a basis for developing new approaches to the

understanding of pain, and the relationships between pain, gender, culture and embodiment.

The main findings are explored in detail in Chapters 5, 6, 7, 8 and 9. They can be summarised as follows:

1. Most people perceived women to have a superior capacity to men for coping with pain, or there to be no gender differences: a minority said that men were better at coping with pain.
2. In explaining these differences, interviewees identified female hormonal and reproductive functioning and the role of motherhood as equipping girls and women with a 'natural' capacity to endure pain, whereas no such biological preparation was identified for boys and men. Conversely, male socialisation was seen actively to discourage males from being allowed to express pain, whether physical or emotional. Expressing pain was thus considered a state of 'abnormality' for males, in contrast to the 'natural' attribution for females.
3. Analysis of the interview data, which incorporated responses to visual imagery, revealed that the meanings and definitions of pain for the individual (both women and men), are not confined to physical sensations, but do include feelings and emotions, and spiritual and existential notions.
4. These broader meanings were notably more difficult to access using the instrument of a structured questionnaire as distinct from that of a semi-structured in-depth interview.
5. Analysis of the questionnaire data showed that men were less inclined to think the emotional component of pain perception had any importance. However, in the interviews the male sub-sample discussed their feelings and vulnerabilities as freely as the women. All the interview respondents acknowledged the concept of 'emotional' pain, but men



were more likely to separate out these definitions and ascribe a hierarchy of 'respectability' to types of pain, whereas women gave more holistic, integrated accounts of their experiences.

These findings can be analysed on different levels. Below, the theoretical, methodological and policy implications are considered in turn. Finally, the contribution of the research as a whole to work in the area is discussed, along with directions of future research suggested by it.

## **1. Theoretical implications of findings**

### **(a) Concepts of pain**

The research presented in this thesis aimed to initiate a significant sociological contribution to the area of pain perception. This field has been dominated by psychophysical research, premised on the Cartesian dualism dominating Western medicine, and the resulting parallel divides between mind/body and emotion/sensation, which have been shown to limit and restrict treatment and therapy. Following the dualistic mechanical model, the conceptualization of pain has traditionally been informed by medico-psychological approaches, amongst which the Gate-Control theory has been foremost in emphasising the significance of psychosocial and cultural variables.

At a conference on New Directions in Health in 1982, Dr. Marsden Wagner, a physician with the World Health Organisation, pointed out that medical care used to combine art and technology at a ratio he estimates at 9:1, until medicine became attached to what he describes as 'the rising star of science and classical mechanical physics'(1982:1207). Theoretical dichotomies, rooted in ancient Greek philosophy, were given added weight by Descartes, who:

'...at the beginning of the modern era, argued persuasively that the only path to knowledge was the scientific side of the dichotomy and that we must ignore or control the artistic side. This one-sided mechanistic view was applied to medicine, and the body and disease processes came to be seen in those terms' (Wagner 1982:1207).

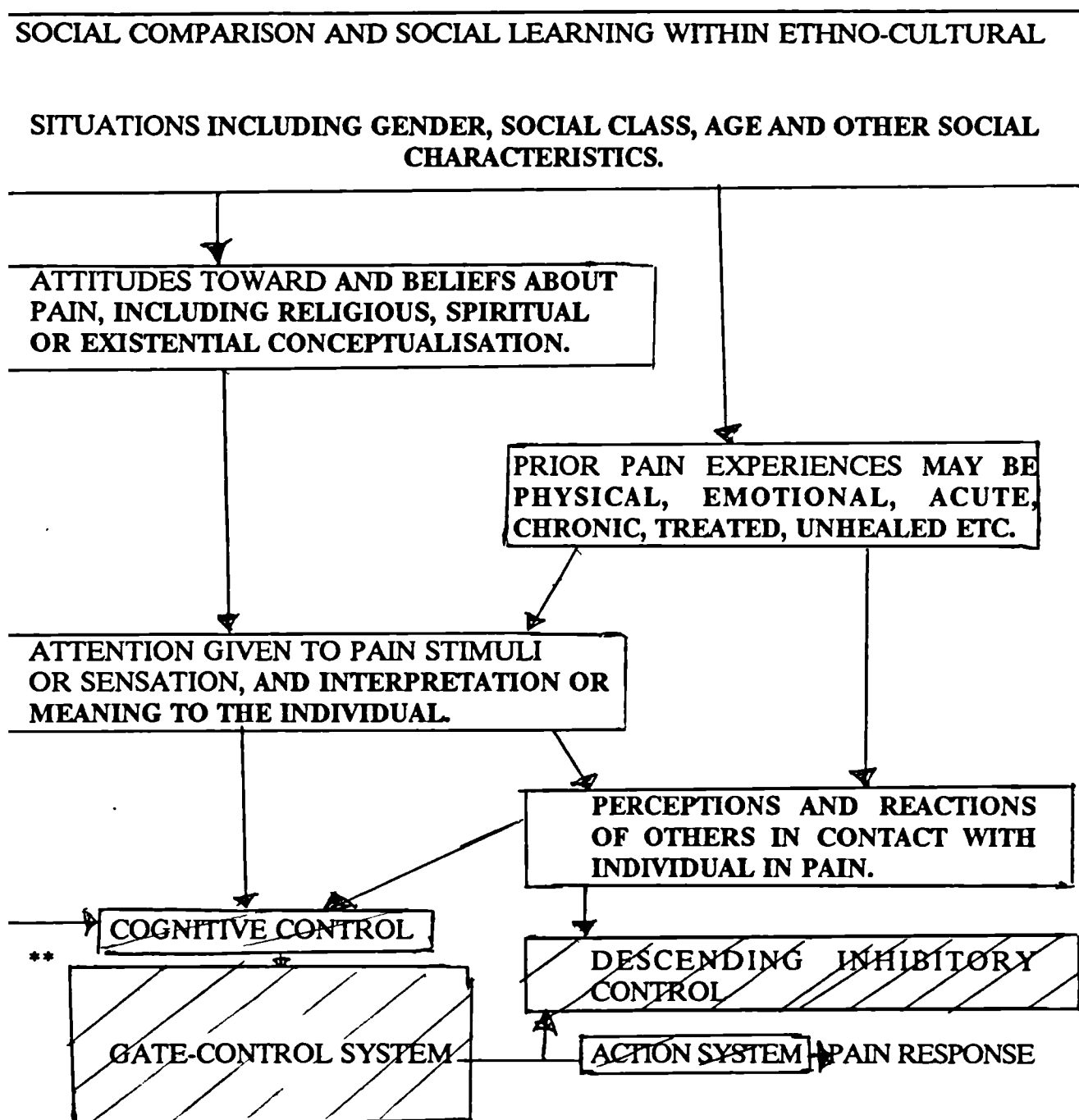
The dichotomies of art and science, intuition and logic, and subjectivity and objectivity have resonances with the qualitative/quantitative and feminine/masculine splits described in earlier chapters. The body of work around the medicalisation of childbirth, particularly the contribution of feminist sociologists (see the critiques of medical practice by Oakley (1980) and Roberts (1985) described earlier), has achieved some advances in transcending this dualism. The current work takes the form of a parallel exercise for pain by locating it in a context which, like childbirth, unites nature and culture.

The original Gate-Control theory, shown in the shaded portion of Figure 10:1, has recently been revised (see Bates 1987) to take account of cultural factors, including:

1. Attention given to pain stimuli or sensation.
2. Attitudes towards pain.
3. Prior pain experiences.
4. Social comparison and social learning processes within ethno-cultural group situations.

The findings from the present study would expand the model still further, as shown in Figure 10.1. To the social comparison and learning factors across the top of the figure is added the structural differentiation produced by gender, class, age, and other forms of social stratification. Underneath this, beliefs about pain join forces with attitudes and concepts derived from religious and spiritual belief systems. Even though a person may not practise, and may consciously reject, religion, most cultures are shaped and moulded by external belief-systems, which affect and inform their perceptions of illness and pain.

**FIGURE 10.1. An expanded version of Bates'\* Bio-cultural model of pain perception.**  
(Additions in bold type)



\* see Bates M. (1987):49 'A Bio-cultural Model of Pain Perception'.

\*\* original Gate-control Model theory, see Melzack R. Wall P. (1965) :972.

As Cornwell (1984) has demonstrated, 'lay' knowledge of health and healing may be composed of 'commonsense' notions or superstitions, as well as religious beliefs, and may conflict with scientific, rational and technical perspectives, which regard them as irrelevant. However, these beliefs remain highly pertinent to the individual, and have been demonstrated to affect treatment and outcomes of pain therapy (Williams and Thorn 1989; Priel et al 1991). Prior pain experiences, shown next in Figure 10.1, are differentiated into physical, emotional, acute, chronic, treated, untreated, etc. Specific pain stimuli not only provoke attention from the individual, but are individually interpreted, and thus given 'subjective' meanings. A significant factor here is how others perceive and respond to the individual in pain. These factors all feed into how pain is perceived, experienced, reacted to, and expressed physically, mentally and emotionally.

**(b) Medical practice and social values**

A more holistic understanding of pain is clearly relevant to medical practice on a number of different levels. The inability of medicine to explain experienced pain for which there is no 'demonstrable' pathological cause has led to an increased emphasis on socio-cultural variables. Using a semiotic perspective may be especially valid for chronic pain syndromes, where pain is symbolic of either inner or outer conflict. People in pain, of whatever type, may need their pain 'validating' before they can cope with it. Underlying such considerations, the 'faulty-machine' model of embodiment does not provide an approach adequate to the task of understanding the subjective meanings of pain. Professor Lynch, of the University of Maryland Medical School, suggests that another way of treating people is possible:

'Clinicians will be required to make a fundamental change in the way they think about the human body. it will no longer be sufficient, for example, to interpret rationally the meaning of various cardiovascular shifts that occur when a patient talks about emotional struggles. Rather, it will also

be necessary for clinicians to interpret emotionally and feel the struggles that such bodily codes signify.

The social distance built into current ways of looking at the human body - the view of an objective scientist looking at another bodily object that is clearly separate and distinct - will be expanded to include a new type of social connectedness, where two human beings will be able to share commonly felt emotional experiences at their social membrane. In the new clinic, immunization from the emotional experiences of one's fellow man will no longer be seen as either a vital necessity or a particularly virtuous aspect of scientific objectivity. Such detachment will be seen instead as part of a stance that embraces a limited view of the human body in dialogue with others, as well as a restricted view of factors beyond bodily mechanics which influence health' (Lynch 1985:281).

The plea for the recognition of the impact of human emotional states on medical treatment which is at the heart of a more holistic understanding of pain is not new. In his book The Broken Heart: the Medical Consequences of Loneliness (1977), Lynch presents evidence to demonstrate the links between cardiovascular disease and emotionally distressing life events. He uses medical technology to demonstrate emotional states, for example electro-encephalographic (E.C.G.) patterns showing dramatic improvements when a nurse holds a patient's hand. In a later work, Lynch (1985) develops his thesis further, using a Foucaultian analysis to understand how the doctor-patient relationship has become divorced from its social and economic context. He predicts the growth of 'new clinics' in which the process of 'disembodiment' of symptoms will be accelerated by the generalized use of computer graphics, and emphasises the need for a philosophical shift away from the vision of the human body as purely a group of sophisticated mechanisms.

Aside from specific medical practice issues, there are implications on a broader social level of new approaches to understanding pain. Potentially serious implications stem from the separation of reason and feeling, not only for medical practice, but for human culture in general. Instead of the hopes of a new and better world, designed to end ignorance and superstition, that Descartes envisaged would be based on reason, the

ultimate implications of rationality can be seen in a more sinister light:

'It was an idea that at first sparked off great hope and optimism in the West. Yet it was also a blind hope which was crushed forever in the madness of the sheer rationality of Auschwitz, where the mathematical idea of a final solution bore witness to a terrible flaw in the philosophical foundations of modern Western civilisation. For it was there, in one of the most sophisticated of all Western nations, that men who were clearly rational were also clearly incapable of hearing the cries of human suffering. If Germany was the most scientific - that is - rational of all nations - and if it had the most advanced medicine in the Western world, it was nevertheless a medicine almost totally deaf to those cries. To believe, however that such deafness was peculiarly German, or the result of an aberration in what has otherwise been an inexorable movement towards greater enlightenment, is to feed the very same disease that produced this human catastrophe in the first place' (Lynch 1985:309).

The need to understand by what perceptual process it is possible for one human being to stand beside another in agonizing pain, and not to recognise that he may be inflicting that pain, is evoked as a central issue in a powerful linguistic analysis of the nature of pain by Scarry (1985). Her book, The Body in Pain: the Making and Unmaking of the World suggests that torture is an extreme event parallel to war. The object of war is to kill people, whereas torture mimes the killing of people by inflicting pain. Scarry maintains that torture is an imitation of death,' a sensory equivalent, substituting prolonged mock execution for execution' (1985: 27), and is made more frightening by its 'acting out' properties. By inflicting bodily pain, it destroys and replaces personal language with the objectification and 'deconstruction' of the body and the person.

Any investigation into the nature of pain must include philosophical consideration of the capacity of humans to inflict pain on both their own, and other, species. Arguing polemically, both torture and war can be regarded as are essentially masculine phenomena, counterposed to feminine ways of thinking, understanding and acting (see Belenky 1986; Ruddick 1990). This highlights the importance of an approach to perceptions of pain which is sensitive to the social construction and operation of gender differences. The material gathered in this study suggests that gendered notions about pain

(interlinked with class, race and other social characteristics), plus the importance attached to emotional aspects of pain, are relevant themes here. These themes connect to each other, as well as to more fundamental philosophical issues.

### **(c) Gender and pain**

In the literature on pain perception, either gender is not seen as a variable of any significance, or females are thought to have lower thresholds than males. The focus on sex differences in thresholds and tolerance, appears to be the **only** issue regarding gender and pain perception to have received any systematic attention.

Gender differences are most likely to be recorded in sensitivity to experimentally induced pain; a recent experiment which inflicted a noxious heat stimulus on a 'normal' sample of undergraduate men and women (Feine et al 1990) concluded that there was a biological basis for the lower thresholds of the women. Whilst asserting this finding as the most 'logical' explanation, the authors suggested that another interpretation could be that men delay responses more than women. The issue of these observed sex differences reflecting response bias remains unresolved. In contrast to the psychophysical research conducted on thresholds and tolerance, the findings of the present study which looks at **beliefs** about pain, reveals a superior coping attribution in favour of women. Very few men (17%) or women (8%) saw a superior male capacity in this area, whereas 66% of women and 33% of men thought that women coped better, and 25% of men and 42% of women thought there were no differences (significant at the  $p < 0.05$  level.) In other words, the perceived ability of women to cope with pain appears to be a heavily gendered notion.

In the explanations research participants gave in both the interviews and questionnaires for the present research, biological principles for these differences were cited, but along with broad socio-cultural themes of roles and socialisation. Both men and

women believed that female hormonal and reproductive functioning and the role of motherhood equip girls and women with a 'natural' capacity to endure pain, whereas there is no such biological preparation for boys and men. Although it was felt that women were more likely to admit to being in pain and to seek help or treatment, their assigned social roles made it less possible for them to adopt the sick role and restrict their activities. Both sexes felt that it was culturally more acceptable for women to express pain. Childhood socialisation was thought to lead males and females to differ in their perception, evaluation and response to symptoms. Male socialisation was actively seen to discourage males from being allowed to express either physical or emotional pain. Such expression was seen as a state of 'abnormality', in contrast to the assumptions of 'naturalness' in females.

Assumptions of 'naturalness' about female pain coping capacities are linked to structural social divisions by gender, particularly between public and private domains. Women have historically been more closely involved than men in the domestic sphere, and have therefore also been associated with the 'natural' world in the form of bodily (implying lower status) functions. Major features of this division are female biology, particularly menstruation and reproduction (see Martin 1987; Laws 1990) and the rearing of children, a 'social' role which is often ascribed biological status. By comparison, men are more involved in the public world of work and therefore 'higher' cultural and mental processes:

'It is no accident that 'natural' facts about women, in the form of claims about biology are often used to justify social stratification based on gender' (Martin 1987:17).

Although similar cultural claims about minority groups are often presented as biological or 'natural' facts, those who make these claims may be able to separate themselves from those groups in a way they can never hope to separate themselves from women:



'Not only do most of them have a woman raising the kids at home, all of them surely believe that their children are genetically related - connected by shared biological substance - to their wives as well as themselves. Flaws in women might seem to have implications for their own families...' (Martin 1987:18).

Possible cultural explanations as to why women are thought to cope better with pain include the following:

1. Their greater readiness to report pain/talk about feelings;
2. The greater likelihood that they will act on symptoms/seek support or help;
3. Their childhood socialization to be caring for others/have more imagination about how it feels to be in pain/distress;
4. The fact that women's ontological security and sense of identity is less threatened by admitting to pain than is the case for men, where the psychological structure of masculinity is predisposed to inhibit the admission of vulnerability.

The attribution to men and women of different capacities for experiencing, expressing, understanding and responding to pain is linked to gender-differentiated socialization processes. Here the work of theorists such as Chodorow (1979) and Martin (1987) draws attention to the ways in which the experience of embodiment may be fundamentally differentiated for male and female children by virtue of the gender-asymmetrical nuclear family system. Physical experience of the body is modified by the social categories through which it is known. Therefore all theories about its care, its lifespan, its abilities, its functions, its ability to stand pain, emanate from a culturally processed and located idea of the body. The experience of living in a body and being a gendered body in a hierarchically organized gender-differentiated world must have an impact on the ways in which different forms of pain are experienced and expressed.

Both female and male respondents in the interviews for the present study expressed the opinion that men (particularly those who are white, heterosexual and working in non-manual occupations), would take longer to admit to being in any type of pain, or to seek treatment, but would be likely to receive more attention and be taken

more seriously, whether by health workers, or others around them. These suggestions are supported by studies of social characteristics and health service use (see Whitehead 1987). They are also confirmed by both historical and contemporary studies of the attitudes and behaviour of health professionals. For example, the following account from the Maine Medical Journal entitled 'Painful Women' appeared in 1932;

'Whenever I ask a female to state her symptoms, and she replies, "I have so many that I have written them on this slip of paper, in order not to forget them", it has a decidedly bearish effect on my spirits. I know, if I let her talk herself out, that eventually she will incriminate herself, albeit in the meantime I am suffering like a she-elephant in the pangs of childbirth, for I am confronted by a hypochondriac.

One may indulge in the luxury of terminology here and call these [women] neurasthenics, or psychosthenics, examples of anxiety neurosis or just plain variants. In any case, they are the bane of the average physician's existence, for they tax his medical skill, his tact, his patience and his endurance to a degree not at all commensurate, as a rule, with their ability to pay... The existence of a sociologic problem oftentimes only becomes apparent after painstaking and persistent enquiry. the patient comes with a somatic complaint and carefully conceals her bizarre reaction to an unhappy experience such as a thwarted ambition, a petty jealousy, a husband with the technic of an English sparrow, or a desire to escape the responsibilities of life in the home, or in the business or social world. Examples may also be found among those women who having rushed madly into some much-needed uplift work or reform, only to discover later that their object is unworthy and their noise a lot of ballyhoo, develop symptoms which confine them and thus excuse themselves, because manifestly, one does not expect the sick to work. They include the colourless, uninteresting negative types, who, craving attention (as do all of us more or less) and receiving it not, fly to disease, knowing that illness calls forth sympathy, interest, inquiry, in general, **attention**, which is the thing desired'(Gehring 1932:139-140)

Although the article goes on to make some pertinent connections between emotional states and physiology, the stereotyping of women (and therefore implicitly of men) by male medics is all too obvious. Many examples of this, and other forms of discrimination can be found throughout the older literature. Some sixty years later, in an era which is sometimes termed 'post-feminist', it may be argued that we are much enlightened. Some of the respondents (male and female) in the present research expressed the view that women have achieved equality, and have no further need to pursue their cause, and that

doctors and other health professionals would not differentiate between male or female patients in terms of treatment. However, a recent paper by two medical sociologists who teach sociological and epidemiological aspects of medicine to medical students at a well-known London teaching hospital (Humphreys and Elford 1990), describes how so-called enlightened attitudes may exist only on the surface of public expression. Throughout the term's teaching, students of both sexes consistently displayed public attitudes of awareness of gender and other social issues to both their teachers and their peers. At the end of term, it had become traditional for the students to present an (unevaluated) summary of their learning to their tutors, which could take any form of presentation. The group of students under discussion chose to perform a satirical revue consisting of sketches depicting 'typical' scenarios in a G.P. surgery. The authors were somewhat dismayed to witness the resulting 'hymn to sexism and cross-dressing, a field-day for parody and stereotype' portrayed with great hilarity by both male and female students, for example:

'One group had considered the rise of alternative medicine. They presented three sketches - in each one a weird, neurotic woman goes to her conventional male GP with a problem - a chain smoker who wants to give up: somebody who suffers from constant headaches: a woman with a large lump on her back. The GP shows no interest in their problems so off they go to alternative practitioners, whom the GP clearly thinks are as peculiar as their clients. A hypnotist swings his pocket watch in front of the chain smoker and she is immediately cured of her addiction. The woman with the headaches goes to a homeopath. 'Hello doctor you're a HOMO..'No, I'm a HOMEOPATH'. Much laughter. An acupuncturist sticks a needle into the lump on the third woman's back - it's a balloon and bursts with a loud bang. The G.P. has been watching all this and mutters something about peculiar patients going to strange magical healers. whereupon he takes off his trousers to reveal he is wearing black stockings and suspenders. We are to believe that he is the strangest of all' (Humphreys and Elford 1990:172).

Another group examined the relationship between mental health and the social roles of women:

'A distraught woman patient is trying to get into the surgery to see her G.P.. Meanwhile, the female receptionist is seducing the male doctor. "Time for your massage, doctor", as she kneads his shoulders. "Can I take

some notes?" as she climbs all over him... even when the patient is admitted into the room, the receptionist continues to fawn and frolic. The patient is depressed and talks about her domestic circumstances. Her mother died when she was young, she has three children under the age of five at home, she has no close friends. The "Professor" then clambers onto the table and starts to lecture us, in an absent-minded way, about vulnerability factors and provoking agents which may explain why the women is depressed, accompanied by much ribald laughter...' (Humphrey and Elford 1990:173) .

When the lecturers attempted to set up a meeting to discuss some of the issues raised, in 'a relaxed, non-confrontative manner', they were advised by their senior (medical) colleagues to drop the matter and put it down to 'high jinks' - of course only 'natural' for a group of medical students. This episode could be interpreted as an alarming complacency within the medical establishment to perpetrate the status quo of the (heterosexual) male domination of society. Of course, this does not apply solely to the medical profession. It is well-documented as a structural phenomenon of our society, as expressed by Mayall and Foster (1989) in their consideration of the value-systems of health professionals:

'It is of particular concern that in Britain a rigid set of monocultural social values congenial to men are urged on a plural, multiethnic society where women are disadvantaged and those who are not white, indigenous and middle-class especially so' (Mayall and Foster 1989:2).

#### **(d) The role of emotions**

A brief review of some of the literature on emotions in Chapter 2 pointed out the increasing interest of sociologists in the social functioning and cultural shaping of emotions. The findings of the present study demonstrate that emotions represent an important juncture between the mental and the physical, the mind and body and the individual and society, and are especially relevant to the understanding of pain perception. Like emotions, perceptions of pain differ from other senses such as sight or vision because they do not require a particular environmental energy, and the identity of the individual and her/his personal belief and value systems appear to affect how pain

is evaluated and interpreted. These factors also help to shape the expression of pain, which in turn reflects the individual's social context.

Pain is not always seen as negative, especially if it is acute, easily observable and the cause is established. Childbirth was described by respondents as 'productive' pain, and many people endorsed the notion of pain as having a 'signal function' (attributed to emotions by Hochschild (1983) and described in detail in Chapter 2), as being a sign of both biological and emotional health. Nevertheless, hierarchies of 'respectability' were ascribed to different types of pain. Emotions were only mentioned by 4% of the questionnaire sample but the concept of 'emotional pain' was acknowledged by 100% of the interview sample. There were gender differences in attitudes to this concept. For men especially, physical pain appeared to command more respect, legitimation and sympathy and most were reluctant to see pain without a pathological cause as 'real' pain. Although the women in the sample did make distinctions between the physical and the emotional, they were more likely to describe their experiences in an holistic, integrated fashion.

Emotional pain was presented in terms of 'popular' concepts from humanistic psychology, and psychoanalytic influences. Most of the respondents articulated the idea in some form that 'bottling up' feelings, and not being able to express emotional conflict or hurt, causes damage. However, to be able to express this distress in a 'safe' manner is seen as problematic, especially for men. So although being able to express emotions is on the whole seen to be a 'good' thing, something that promotes health, it is double-edged, both in the sense of the vulnerability incurred by being seen to be 'weak', and the fear that is invoked by displays of emotion to others. If pain of any sort becomes severe enough, there is a complete lack of control, which for many respondents is the worst aspect of pain they can imagine. However, 'real' acute pain with an easily demonstrable cause, for instance, injuries sustained through sport or battle, have a respectable status

and demand instant attention. Less physically obvious 'hurts', especially emotional ones, may not be revealed due to fears of personal vulnerability. Feeling safe enough to seek help thus depends on the social context.

The concept of 'emotion work' involves the management of emotions of the individual in order to conform with the demands of the particular social situation. These include both the subjective states, and more public bodily displays. Hochschild (1983) has coined the phrase 'status shields' which are the socially distributed resources that people have for protecting their sense of self in differing social situations. Again there is the theme of the division between work/home, the private sphere is seen as more appropriate than the public. The tendency towards stoicism, the traditional British 'stiff upper lip', is often portrayed with pride, and may be continually instilled throughout childhood socialisation, especially for boys. However, negative consequences of the tendency to not express ourselves can occur when symptoms are ignored, either by the sufferer themselves, or those who are supposed to be caring for them. In health care (and no doubt in other areas of care), there is a tendency to label any sick role behaviour as 'attention seeking' at best and malingering at worst, when in fact it may be the perceptions of the carers which need examining. Priel et al (1991) demonstrate how the patient in pain needs to find a **meaning** for their symptoms, even if it is 'dysfunctional'. Without such a meaning feelings of despair and isolation may develop. Explanations may be linked to deeply entrenched religious or a spiritual beliefs, even if an individual does not follow any particular faith. The research carried out for this study shows that punishment and self-blame are common themes. Whereas they may seem inappropriate and even anti-therapeutic to the physician, these beliefs may preserve a sense of self-identity for the sufferer, in the face of impersonal rationality that medicine may impose.

## **2. Methodological implications of findings**

### **a) A multi-method approach to pain perception**

The methodology of the research was designed in order to reflect theoretical considerations centred on divisions between mind and body, emotions and sensations and subjectivity and objectivity. Hence quantitative and qualitative approaches were used. It was felt that using a multi-method approach might overcome some of the inherent problems of measuring pain revealed in the literature review.

Brannen (1989) notes that there is a considerable lack of literature on combining quantitative and qualitative methods. In the examples she found of combined work, it was more common to find linked studies conducted by separate teams of researchers than to find integrative practices within the same study. Each approach is linked theoretically to a different tradition of treating data:

'In theory, if not in practice, the quantitative goal is to isolate and define variables and variable categories which together constitute the data. This is done in the expectation of framing hypotheses concerning the relationships between variables before the study is undertaken. The qualitative approach, on the other hand, typically isolates and defines categories (rather than variables). These categories are expected to change their nature and definition as the research progresses. For the former, variables are the means of research while, for the latter, they are an outcome. Still more strikingly, the qualitative researcher looks through a wide lens, searching for patterns of inter-relationships between the many categories, while the quantitative researcher looks through a narrow lens at a limited set of them' (Brannen 1989:3).

Brannen outlines two other important distinctions between quantitative and qualitative approaches:

- 1) in the collection and reporting of data;
- 2) in the propensity to generalise and make inferences. Quantitative investigators use pre-determined instruments, which aim to produce incidences and frequencies, whereas in qualitative research

'... the researcher must use herself as the instrument, attending to herself and her own cultural assumptions, as well as to the data. In seeking to achieve imaginative insights into the respondent's social world the investigator must be endlessly flexible and reflexive, and yet somehow manufacture distance' (Brannen 1989:3).

Rather than producing frequencies, the aims of qualitative research are intensive, and have to do with creating categories and inferences. The differences in approaches have diverse philosophical origins, with quantitative methods being rooted in positivism, and qualitative in humanism (see Chapter 1).

So-called objective measures such as pain scales are unable to transcend the mind-body dualism. They limit how pain is defined. Although the issues of subjectivity and articulation have been addressed by medical researchers with the widespread use and adaptation of the McGill Pain Questionnaire (Melzack 1975), psychology has been more resistant to deviating from the experimental psychophysical paradigm. An unresolved methodological issue concerns the feasibility of generalizing observations onto clinical populations of 'normal' subjects experiencing induced pain. To demonstrate this dilemma, a study by Lander et al (1989) monitored three populations of patients to determine whether perceived pain intensity was related to sex. The first group consisted of 100 boys and 100 girls aged 4 to 6 years who were receiving pre-school immunisations. The second group consisted of 75 post-surgical patients (41 men and 34 women aged 18 to 61 years) who were having a surgical abdominal incision cleaned and packed. The third group of 78 patients (48 women and 30 men aged 18 to 61 years) were suffering from knee pain caused by osteoarthritis, rheumatoid arthritis, or traumatic arthralgia. An 11-point scale was administered to adults, and a modified 4-point one to children (all subjects and data collectors were blind to the purpose of the study). Using a chi-square analysis, no significant sex differences were found in any of the groups. The authors point out that although clinical pain is not as 'controlled' as laboratory techniques which induce noxious



stimuli pain, the varieties of pain enabled satisfactory comparisons to be drawn. They emphasise the importance of these results:

'... because as researchers and clinicians we often overhear views expressed that either men or women are more tolerant of pain in clinical settings. Perhaps what influences clinicians' beliefs and ultimately their judgements are sex differences in pain **behaviours** rather than differences in pain **sensitivity**' (Lander et al 1989:1090).

The research presented in the present study falls into the category defined by Brannen (1989) as 'the pre-eminence of the qualitative over the quantitative' (1989:36). In this, quantitative methods are subservient to the qualitative ones. They provide background data in which to contextualise a small-scale and intensive piece of work. The questionnaire used in the study provided a wider sample, whose characteristics could be compared to those deployed in other health surveys. The opinions and beliefs about pain revealed in the questionnaire study formed the basis of the in-depth work. A major objective was to explore respondents' own **feelings** about their experiences of pain, in order to produce interpretative, rather than clinical data. In contrast to more traditional methods of 'measuring' pain, the analysis of the interview data shows that the meanings and definitions of pain to the individual are not confined to physical sensations, but incorporate feelings and emotions, even spiritual and existential notions. And, as noted earlier, the complexity of these beliefs proved much more difficult to access by questionnaire format.

#### **(b) Exploring the use of visual imagery in data collection**

In addition to combining quantitative and qualitative methods, an innovatory approach to 'tapping' pain beliefs was initiated by using visual imagery to elicit responses relating to the conceptualisation of pain.

A series of visual images, collected from art galleries were used to tap men's and women's perceptions of pain. The images show men, women and children in different

types of pain and in varied social circumstances. The idea of using visual images in order to probe more deeply into beliefs and attitudes about pain emerged from an interest stimulated by Berger (1969) and others in the relationship between art and society. The methodological basis for using visual images to tap pain perceptions in the Ph D research also followed the work of Finch (1987) and others who have employed the 'vignette' technique in sociological research. The approach was successful, in the sense that nobody refused to take part and all except two interviewees claimed to enjoy the exercise, some even claiming to find it therapeutic. Having revealed in some depth earlier in the interview their own 'pain stories', interviewees seemed to find it a relief to turn from the personal to a more public aspect, namely to something that was happening to someone else. A further advantage of using images is that this technique elicits an immediate response and does not necessarily require a high level of articulation, as can be the case with other interview procedures. Because the set of images is standardised, a high degree of consistency between different interviewers in data collection methods can be guaranteed.

The visual image technique was used in this research in combination with others (self-administered questionnaires, in-depth interviews, 'accounts' of pain, literature reviews), to build up a sociological picture of the ways in which pain is perceived, conceptualized, measured and socially patterned beyond the narrow domain of clinical-medical and psychological meanings in which the study of pain has traditionally been located.

### **3. Future research directions**

In building on the methodology and the findings of the present study, future research needs to take a number of different directions. The common methodological starting point of these is the exploration of a new technique for evaluating pain which

incorporates the systematizing of the 'subjective' element omitted from traditional approaches. The methodological implications of the study clearly lie in developing the use of visual imagery more systematically, and with a larger, and different sample of individuals. An obvious setting to examine further the productivity of this technique in exploring perceptions of pain would be amongst attenders at a pain clinic. (Most attenders have been referred to pain clinics because a 'pathological' cause for their symptoms has been unable to be established.) Another development will be to compare the possible impact of professional training on perceptions of pain by applying the technique to health professionals as well as to individuals using pain clinics. In this work one objective would be to see if the number of images used could be reduced, and how the central issues stimulated by each could be controlled. Fine art and photographic images could be compared for their capacity to stimulate qualitatively different types of information regarding people's perceptions of pain. The visual imagery technique is also of clear relevance to the investigation of cultural differences in pain perceptions, and to the exploration of possible dissonances between the perceptions of health professionals and users of the health services.

From a theoretical point of view, the future development of the research will build on both the sociology of emotions and the sociology of the body as new domains and divisions of sociological labour. Sociological work on emotions is an area that is only just beginning to consolidate theoretically in the U.K. In order to explore the connections with pain perceptions further, the development of international links is needed within this newly emerging field, both in the rest of Europe, and in the U.S.A. Similarly, the sociology of the body is a developing field within which sensitivity to structured inequalities of power, identity and autonomy by both gender and economic class is proving an important theme (see Turner 1991). So far as advancing the understanding

of pain as a gender-differentiated phenomenon is concerned, the sociological frameworks provided by feminist methodology ( see Harding et al 1987), and particularly by feminist epistemology (Belenky et al 1986; Smith 1988) will be crucial. As well as being a medical(ized) phenomenon, pain is a everyday experience linking the subjective sense of self to the perceived 'objective' reality of the world and other people. In these aspects, the gendering of culture must affect and inform the experience of pain. It is thus this process that is likely to hold important clues to the well-documented picture of gender inequalities in health and illness. The experience of pain, which has formed the subject-matter of this thesis, constitutes an integral, and hitherto poorly researched part of this picture. Its exploration does, moreover, both provide and demand the dissolution of the habit of dichotomous thinking which has impeded a unified understanding of cultural and biological inputs to health.

# APPENDIX 1 : QUESTIONNAIRE

201  
OFFICE  
USE  
ONLY

(1-4) SERIAL NO.  
P

(5) Blank  
(6) CARD NO  
(7) Blank 1

pg 1

## HEALTH

1. Over the last twelve months would you say your health on the whole has been

excellent [ 11  
good [ 12  
fair [ 13  
not very good [ 14  
poor [ 15  
very poor [ 16  
9

(8)

2. Thinking about your own life, are there particular things which have a good effect on your health?

[For example: good diet, regular exercise, good relationships, holidays, enough sleep, some control over own life etc.....]

(9, 18)

3. How about things which may have a bad effect on your health?

[For example: overwork, poor housing, smoking, boredom, alcohol etc.....]

(19, 28)

4. So on the whole would you say your life is;

very healthy [ 11  
fairly healthy [ 12  
fairly unhealthy [ 13  
unhealthy [ 14  
9

(29)

(30) Blank

pg 2

ILLNESS

5.

- a) Do you have any long-standing illness, disability or infirmity?  
 [for example, anything physical such as diabetes, arthritis, back pain;  
 anything involving loss of functioning such as deafness, lameness etc,  
 or anything emotional such as depression, anxiety etc.]

(31)

Yes [ 1 ]  
 No [ 12 ]

If no, go to question 6

- b) If yes, please give brief details.....

(32)

- c) How long has this affected you?

Less than 1 year [ 1 ]  
 Over 1 year but less than 2 [ 12 ]  
 Over 2 years but less than 5 [ 13 ]  
 Over 5 years but less than 10 [ 14 ]  
 Over 10 years but less than 20 [ 15 ]  
 Over 20 years [ 16 ]  
 9

(33)

- d) How does it affect what you do from day to day?

Not at all [ 1 ]  
 A little [ 12 ]  
 Quite a lot [ 13 ]  
 A great deal [ 14 ]  
 Totally [ 15 ]  
 9

(34)

- e) Do you have any treatment/ support?

No [ 1 ]  
 Yes [ 12 ]

(35)

If yes, tick if applicable

G.P. supervision [ ]  
 Community nurse visits [ ]  
 Regular medication [ ]  
 Home help [ ]  
 Physical aids [ ]  
 Outpatient treatment [ ]  
 "Alternative treatment" [ ]

(36)

(37)

(38)

(39)

(40)

(41)

(42)

please write in what sort.....

(43)

Other (e.g. support from family, friends etc.) [ ]

(44)

please write in.....

(45)

pg 3 ILLNESS contd

5. f) are you satisfied with the treatment/outcome?

Yes [ 11

No [ 12

(46)

If no, why not?

please write in.....

(47)

6. a) What was the last short-term illness you had?

(i.e an illness that lasted no longer than a month at the most)

(48, 49)

b) How long ago was this?

Less than 1 month ago [ 11

Over 1 month but less than 6 [ 12

More than 6 months but less than 1 year [ 13

Over 1 year but less than 5 [ 14

Over 5 years but less than 10 [ 15

Over 10 years [ 16

9

(50)

c) Did you seek any treatment?

No [ 11

Yes [ 12

(51)

If yes, tick if applicable

Medicine from chemist [ ]

Home remedy [ ]

Went to G.P. [ ]

Went to out-patient dept. [ ]

"Alternative treatment" [ ]

please write in which sort.....

Other [ ]

please write in.....

(52)

(53)

(54)

(55)

(56)

(57)

(58)

(59)

d) were you satisfied with the treatment?

Yes [ 11

No [ 12

(60)

If no, why not?

(61)

(5) Blank

(6) CACD NO.

☐ 2

(7) Blank

PG 4

## PAIN

7. a) Have you ever had an injection or a blood test?

Yes [ 1 ]  
No [ 12 ]

(8)

b) If yes, in terms of feeling physical pain, how would you score it on the following scale?

(9)

(please tick)

I	I	I	I	I	I	I
1.	2.	3.	4.	5.	6.	
no pain						severe pain

8. a) If you are female, have you ever given birth?

Yes [ 1 ]  
No [ 12 ]

(10)

b) If yes, how would you score the pain of labour on the following scale?

(11)

(please tick)

I	I	I	I	I	I	I
1.	2.	3.	4.	5.	6.	
no pain						severe pain

9. Pain is increasingly thought to be connected to emotions.  
How far do you think this is true of the following:

(please tick)

Not at all   A little   Quite a lot   A great deal   Completely

a) anxiety

(12)

b) depression

(13)

c) fear

(14)



## Pg 5 PAIN contd.

- 0 a) Do you think men and women differ in their ways of dealing with pain?  
( Please tick)

Women are able to endure more pain than men [ ]<sup>1</sup>  
 Men are able to endure more pain than women [ ]<sup>2</sup>  
 There are no differences [ ]<sup>3</sup>  
 9

(15)

- b) Why do you think this is?

(16, 17)

- 1 a) Could you describe the worst pain you've ever had, and what you think caused it ?

(18, 19)

- b) On the same scale as before, how would you score it?

(20)

(please tick)

I \_\_\_\_\_ I \_\_\_\_\_ I \_\_\_\_\_ I \_\_\_\_\_ I \_\_\_\_\_ I \_\_\_\_\_ I \_\_\_\_\_  
 1. 2. 3. 4. 5. 6.  
 no pain severe pain

- c) How old were you when this happened?

\_\_\_\_\_ yrs

(21, 22)

- d) Did you seek any treatment/ help

No [ ]<sup>1</sup>  
 Yes [ ]<sup>2</sup>

(23)

- e) If yes, where from ( tick any of following if applicable)

Casualty Dept. [ ]  
 G.P. [ ]  
 Other hospital dept. [ ]  
 Family [ ]  
 Friends [ ]  
 Other [ ]

(Please write in).....

(24)

(25)

(26)

(27)

(28)

(29)

(30)

- f) Were you satisfied with the treatment/help you received?

Yes [ ] (go to g) 1

(31)

No [ ] (go to h) 2

pg 6

PAIN contd

g) If yes, who helped you the most/ gave you the most relief?  
(please tick)

(32,33)

Nurse 1 [ ]  
Doctor 2 [ ]  
Member of family 3 [ ]  
Neighbour/friend 4 [ ]  
Other 5 [ ]

(Please write in).....

h) If no, why not?

(34)

11.a) Are you in any pain at the moment

NO 1 [ ] (go to pg 7) 1 (35)  
YES 1 [ ] (go to b) 2

b) What do you think is causing it?

(36)

c) Have you tried to get any treatment/ help for it?

NO 1 [ ] (go to f) 1 (37)  
YES 1 [ ] (go to d) 2

d) Where was this from?

( Please tick any that apply)

G. P. 1 [ ] (38)  
Chemist 1 [ ] (39)  
Physiotherapist 1 [ ] (40)  
Community nurse 1 [ ] (41)  
Osteopath 1 [ ] (42)  
Acupuncturist 1 [ ] (43)  
Member of family 1 [ ] (44)  
Neighbour/ friend 1 [ ] (45)  
Other 1 [ ] (46)

(Please write in).....

e) Are you satisfied with the treatment/ help you have received?

Yes 1 [ ] (47)  
No 1 [ ]

If no, why not?

(48)

f) If you have not sought help/ treatment so far, is there anything you would like to do about it in the near future?

(49)

pg 7

BACKGROUND DETAILS

Thank you for answering the questions so far. Now, if you don't mind, I'd like to ask you a few details about yourself. The purpose of this is to see whether people in different circumstances have different experiences.

1. Please give your date of birth. — — — (51,52)

2. Are you

female [ 1 ]  
male [ 1 ]

(53)

3. Do you live

(please tick which apply)

On your own [ 1 ]  
With partner/ husband/ wife [ 1 ]  
With your children [ 1 ]  
With other(s) [ 1 ]

(54)

4. Could you tell me your nationality and where your parents came from originally? (55-58)

5. Are you doing any form of paid work at the moment?

NO [ 1 ]  
YES [ 1 ]

(59)

(If no go to q.6)

a) If yes, what kind of work is it? (60)

b) How many hours a week do you work?

1-10hrs [ 1 ]  
11-20hrs [ 1 ]  
21-30hrs [ 1 ]  
31-40hrs [ 1 ]  
40+ hrs [ 1 ]

(61)

6. If you are not in paid work:

a) What was your last job, if any? (62)

b) Do any of the following apply to you now?

Retired [ 1 ]  
Full-time study [ 1 ]  
Voluntary work [ 1 ]  
Full-time childcare [ 1 ]  
Caring for elderly relative(s) [ 1 ]  
Unable to work due to illness/disability [ 1 ]  
Other (please state)..... 7

(63)

c) Are you receiving any state benefit?

(Other than child benefit)

Yes [ 1 ]  
No [ 1 ]

(64)

pg 8

BACKGROUND DETAILS contd.

7. At what age did you leave school? --

(65)

8. Do you have any of the following or their equivalent from another country?

GCSE	[ ]	0
CSE/ O LEVELS	[ ]	1
HNC/ONC/A LEVELS	[ ]	2
Professional qualifications (e.g Nursing).....	[ ]	3
Higher educational qualifications.....	[ ]	4

(6)

9. Regarding housing, do any of the following apply to you:

Private unfurnished tenant	[ ]
Private furnished tenant	[ ]
Council tenant	[ ]
Housing association/co-op tenant	[ ]
Owner-occupier	[ ]
Short-life tenant/squatting	[ ]
Homeless	[ ]
Other (please state)	[ ]

(67)

10. Do you have any additional views about the experience of illness and pain which you feel are important but which have not been covered in this questionnaire ?

pg 9

Thanks again for your co-operation.

In order to find out more of your views on these matters, I am hoping to carry out a small number of follow-up interviews, again in complete confidence and at your own convenience.

If you would be willing to be interviewed please give your name ( just a first name will do) and give a phone number where I could contact you to make arrangements or an address at which I could write to you.

## **APPENDIX 2 Descriptions of Respondents**

**These are subjective accounts of interviews, using field notes.**

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### **RESPONDENT F1 Catherine**

Interview time 1 hour 10 minutes

Aged 33, Catherine describes her ethnicity as white British and lives by herself in her own house, working as a freelance musician, playing the violin for various orchestras. She was very willing to take part in the interview, inviting me to her house, but had no recollection whatsoever of filling in the questionnaire, as she suffers from continual memory loss since an operation to remove a brain tumour which had taken place a year ago. This was, not surprisingly, the most traumatic episode of her life, made all the more so by the fact that the tumour was misdiagnosed as depression for several years previously. The single most painful moment in the whole experience, she describes as :

'... when the inefficient nurse in the hospital changed the reservoir of my external shunt without clamping the pipe first. Indescribable agony!'

Catherine felt that she would not have been able to cope with the experience without the support of her mother during and since this time. Although she feels strongly that the physical impact of what has happened to her is the most devastating, she believes it is strongly linked to emotional aspects of her life, and that factors such as disappointments over her career and the break-up of the long-term relationship with a boyfriend may have contributed to her illness. She claimed to have found talking about the experience valuable, and enjoyed using the imagery, finding much of it of personal significance.

**RESPONDENT F2 Helen**

Interview Time: 2 hours

Aged 67, Helen is a retired nurse (S.R.N.) who left school at age 14, lives in her own flat and describes herself as English, originating from Suffolk. The interview took place on her patio, with interruptions from her very playful kitten who continually attacked the microphone. Two years previously, she had been the victim of a hit-and-run accident which resulted in a fractured skull causing residual memory loss and visual impairment. Regaining consciousness in the hospital was the most painful experience in her life, but she finds it difficult to distinguish the emotional from the physical. Although she is no longer in physical pain, impact on her quality of life is profound, and gives her much anguish. Most of the interview comprised of Helen's account of her feelings and how she coped from day to day, which she recounted in an extremely composed manner. Although she felt she was well-supported by friends she said she found the interview comforting, as she rarely had the chance to talk about how she really felt. Obviously her visual impairment made the exercise of discussing the visual imagery difficult, but she also felt it was all rather pointless and a waste of time; she refused to choose who was in the most pain or which picture she identified with most, and said she would much rather be able to talk directly about her own experience.

**RESPONDENT F3 Suni**

Interview time: 45 minutes

Aged 29, Suni was the mother of four children aged 3 months, 3, 7 and 9 years and engaged in full-time child-care of the youngest two, which made participating in the interview quite difficult for her. She had left school at age 16 with five C.S.E.s and had begun secretarial training but was unable to continue after the birth of the first child. She

lives with the children's father, who she describes as being white, Irish and working as a labourer on a building site. They live in a three-bedroomed Victorian council house which was undergoing some renovation at the time. Suni describes herself as Black British with a Nigerian father and English mother, and feels strongly that there is an inherent racism in British society that acts to disadvantage both herself and her children. She feels that her life is hard due to (mainly) material difficulties, and expressed much unhappiness about the lack of opportunities for herself and her children, but was extremely pleased and grateful to have just moved to this house after many years in a high-rise flat. She did not consider herself to have any health problems apart from a tendency to be overweight, and the most painful experience in her life was emphatically that of her third labour which lasted for 25 hours and culminated in an 'excruciatingly painful' birth. Suni felt that the experience was made worse by her own fear and by humiliation brought on by the attitudes of the medical and nursing staff. She thinks that these factors are as important as the physical experience. Despite the problems of caring for the children at the same time, she made a lot of effort to participate in the interview, but thought the sequence with the images was pointless, and felt that many of the images had nothing to do with pain.

#### **RESPONDENT F4 Elaine**

Interview time: 1 hour 20 minutes

Elaine, aged 37, used to work as a teacher until the birth of her first child when she was 28. Her husband works as a legal aid lawyer. At the time of the interview, her third child was 6 months and the middle child had not yet started school, but she was able to take on some paid child-minding in the comfortable three-bedroomed terraced house to which she invited me. She describes herself as 'white British' and part of 'a typical nuclear



family' for which she seems apologetic. Despite the fact that she did find all three experiences of childbirth extremely painful, she thought that a tooth abscess was the worst experience she could remember. She felt the 'sheer undiluted' nature of the pain, and reacted to the fact that it could have been prevented by earlier dental treatment. The experiences of childbirth may have physically been much worse but were purposeful, and had a positive outcome; for Elaine the memories are mixed with joy and elation as well as pain. She also felt quite strongly that being in pain on an emotional level, through a bereavement, for example, was as valid and could be much harder to bear than physical hurt, although she did not consider herself to have personal experience. She said that she had enjoyed the chance to think and talk about these ideas; she felt that it was all too rare for anyone to ask her opinion about anything other than children, and she put much energy into the imagery sequence.

#### **RESPONDENT F5 Barbara**

Interview time: 3 hours

Barbara was aged 37, described herself as English, originally from Yorkshire, and worked full-time as a secretary for a health charity. We had arranged over the telephone for me to visit her at home, which, on the questionnaire form, she had described as a 'short-life property' shared with unrelated 'others'. I was slightly taken aback when the door was answered by a young woman in flowing white robes who welcomed me into a room filled with the smell of incense and lit with candles. Another young woman brought me some scented tea, and then Barbara entered, and at her signal, the other two withdrew. As I began the interview, I was conscious of a desire to ask about Barbara's lifestyle, which by now I had guessed to be involved with a religious order influenced by Eastern philosophies, but also determined not to appear 'thrown' and to retain my 'neutral'

observer/recorder role. I decided to wait to see what Barbara herself would say.

The interview picked up from Barbara's description in the questionnaire of the worst pain she had experienced, which was peritonitis at the age of 13, for which treatment was delayed. The illness was nearly fatal. This, however, was just the beginning of a stream of chronic abdominal and gynaecological infections which culminated in a total hysterectomy at the age of 27. The whole account was related very gently, almost humorously, despite the amount of distress involved, especially in having to come to terms with the inability to have children. It became apparent that the ability to cope with what had happened had been possible for Barbara by an increasing spiritual awareness of the limitations of the body and the potential of the mind; she had a highly developed philosophy, which she felt gave her an inner strength.

She appreciated the use of the imagery, and felt it developed the themes she wanted to talk about, but it was not until right at the end of the interview, when I asked what she thought was the most important process in the perception of pain, that she explained in specific terms about the group that she belonged to, which completely informed her personal life. Her working life had to be somewhat separate, as she felt she had to dress 'normally' and she rarely told anyone how she lived. She definitely did not want to be seen as part of a 'cult' that forced itself on people, but, at the same time, she felt she was part of a movement that profoundly affected her own life and could have the same effect on others.

## **RESPONDENT F6 Gina**

Interview time: 2 hours

Gina is aged 18, and is in the sixth form at school, studying for 'A' levels. She describes herself as British with Polish Jewish maternal grandparents, and lives with her mother,

younger sister and stepfather in a cramped but welcoming flat rented through a housing co-operative. The interview took place in the kitchen, and the other household members constantly and apologetically asked to come in and were very interested in the research. Gina had some initial reservations about the interview because she felt she did not have much experience of pain, and repeated what she had said in the questionnaire, that her worst memory was of scalding her hand with a kettle when she was 8 years old. She felt that this had the effect of making her more afraid of hot things than she should be, and she felt that fear had a lot to do with pain, although she considered she had a high threshold, due to being very fit and healthy. As the interview developed, Gina thought that from her experience, which she considered limited due to her age, being emotionally hurt was much more damaging than physical pain. With hindsight, she thought that some of the fights she had with her sister were worse than the scalding incident. Her parents' marriage broke up when she was eleven, and she had a very strong memory of her father being in a great deal of pain which he was unable to cope with or express in any way, whereas she felt that her mother was able to 'cope' much better by asking for support and being able to cry. She professed to enjoy the imagery and gave very imaginative analytical responses.

#### **RESPONDENT F7 Jane**

Interview time: 50 minutes

Jane is 47, describes herself as 'white, English, middle-class owner-occupier, living with my accountant husband and two grown-up children.' She had been educated to higher-degree level and works full-time as a fund-raiser for a charity. She arranged to meet me in the bar of a five-star hotel, where she had just given a talk to members of the Rotary Club, and was elated as she had managed to persuade them to make a substantial

donation. Jane appeared to be confident, very articulate and intrigued by the topic of pain beliefs. She illustrated her views with quotes from the classics. Her responses in the questionnaire had been very clinical, describing her worst pain as a back injury which eventually healed satisfactorily. However, once the conversation encompassed the notion that pain could possibly be more than physical, she became saddened and serious, relating an account of a problematic relationship with her son. She felt that he had always been 'a difficult child', unlike her daughter, but from the age of 16 she found his behaviour impossible. He had become withdrawn and anti-social, and eventually turned to drug-taking and attempted suicide. Five years later, helped by psychoanalysis for herself as well as her son, she feels she can accept he will never be part of the 'mainstream' as she sees it, but feels that some sort of relationship has been preserved. It has been the most painful experience she could have ever imagined. Being very frank, she revealed that part of the pain still revolves around whether she is really concerned for him, or about judgements on her motherhood. She was relieved to turn to the images, and brought many personal experiences into them, and said she found the exercise therapeutic, as was the interview.

#### **RESPONDENT F8 Angela**

Interview time: 1 hour 30 minutes

Angela, aged 36, arranged for me to interview her at her office. She works as a residential social worker in a psychiatric hostel. She claimed it would be more difficult to talk at home, due to the lack of space in the privately rented three bedroomed flat which is shared with her husband, teenage daughter and her sister. Angela described herself as Black British, her mother being Irish and her father having emigrated from Jamaica in the 1950s. When I initially contacted her, she was very keen to do the

interview and emphasised how the questionnaire had helped her, as she completed it whilst waiting to see the doctor. She had originally intended to present her G.P. with 'physical' complaints such as 'feeling run down', but was spurred into talking about the pressures in her life, which were feeling especially stressful, as she was still experiencing the bereavement of her mother, who had died six months earlier. Angela thought this had been the most painful aspect of her life. I had talked to Angela several times on the phone before the interview, as she had needed to re-arrange the meeting, and had also sought reassurance about attending an outpatient appointment to investigate lumps in her breasts. When we finally did meet for the interview, Angela had obviously given the topics much thought and provided many profound and articulate insights (see Case Study 2 in Chapter 9). The themes were woven through both her working and personal life and she gave vivid and lucid responses to the imagery material.

## **RESPONDENT F9 Marie**

Interview time: 3 hours (not all tape-recorded)

According to the questionnaire, Marie was aged 56, of Southern Irish origins, and lived in a council flat with her husband and son, working part-time as a cleaner. She had no telephone and had not responded to any of my letters, so I called at her flat on the ninth floor of a high-rise block, to see if she was still willing to see me. She answered the door and recognised me straight away, although it had been six months since I met her in the surgery. She insisted I come in straight away and carry out the interview, saying she was delighted I had called. When she completed the questionnaire, her worst experience of pain had been continuous back pain, but it soon became apparent that her life had become in her words, 'a complete nightmare' since this time as her husband had developed Alzheimer's disease, becoming demented very quickly, and resulting in

incontinence, confusion and aggression. He was in continual danger, not only from living on the ninth floor, but also from his continual chain-smoking, which often sets himself or the home alight, and needed constant surveillance. Marie had refused any statutory help as she was afraid he would be hospitalised. She repeatedly agonized that it was the worst thing that could ever happened, and that she would rather have died than watch this happen to the man she had loved all her life. She felt that the only sustenance was her Catholic faith, but felt she must have done something very wicked to have deserved such a fate. The encounter was extremely distressing and I felt it was impossible to carry out a formal interview. Most of my visit consisted of listening to her plight, and I did not use the tape-recorder for all of the time. However, Marie was insistent that she 'be treated the same as everyone', and in fact seemed to derive much pleasure from creating stories around the visual images.

#### **RESPONDENT F10          Rachel**

Interview time: 1 hour 15 minutes

Aged 34 and 'white British', Rachel had trained as a general nurse and midwife, then took a higher degree in community health and was currently working full-time as an immunisation facilitator. At the time of the questionnaire, she was sharing a furnished privately rented flat with her partner, and described her most painful experience which involved leaving a wound exposed for half an hour whilst the dressing for a skin graft on her leg was being changed as an inpatient. She had already experienced many painful incidents with the leg since she injured it in a motor-cycle incident in Bangladesh two years previously. As well as the trauma of travelling back to England with a smashed leg, she had undergone extensive treatment and plastic surgery, but felt that this incident was made worse by the neglect and humiliating treatment of the nursing and medical staff.

One effect of this experience had been to change direction in her career, and she also felt it changed her conceptualisation of pain, which she had defined in narrower sensory terms. This was further exacerbated by the decision of her partner to leave her, three months previous to the interview, and she felt that the emotional pain she had to endure as a consequence was far worse than any physical pain she had experienced. She claimed to find both the interview and the imagery sequence helpful, but was disturbed by some of the images and found them very distasteful.

#### **RESPONDENT F11      Bridget**

Interview incomplete

Aged 28, Bridget's parents left Eire and settled in London before her birth, but have many relatives still there whom Bridget visits regularly. She works as a sales assistant in a department store in central London and shares a one-bedroomed flat with her partner, who arrived back from work in the middle of the interview, which was taking place in the living room/diner area of the flat. He resented the invasion of his privacy, as he saw it, and was aggressive towards Bridget for not telling him that she had arranged the meeting with me. Bridget was embarrassed and upset and readily accepted my offer to leave, as I did not feel I had any right to insist on remaining. Up until this point, we had been discussing Bridget's problem with a back injury.

#### **RESPONDENT M1 Sean**

Interview Time: 2 hours

Aged 28, Sean works full-time as a double-glazing salesman. He left school aged 16 and has no formal school-leaving qualifications. He lives with his parents, who own their own home, and describes his nationality as Irish, as well as describing his ethnic (and religious) background in great detail (See case study no.1. in Chapter 9). This background bears

much significance for Sean, especially in regard to his health. He suffers from an endocrinal disorder which he does not know the name of, and finds embarrassing to discuss. It involves a hormone deficiency requiring regular injections. He describes the humiliation that this caused him as an adolescent, as many of the normal pubescent changes did not occur, such as his voice breaking, and he did not seek or receive treatment for the condition until the age of 21. Until this time Sean maintains he just ignored the condition, but reflects it has always made him feel 'odd' and marginalised. As the interview progressed, it became clear that he had built up an extremely complex belief system around this condition involving his ethnicity. He saw it as manifesting as a constant 'mental pain', a theme which recurred throughout the interview, and also coloured his view of the most painful experience he could remember, which involved being beaten for wetting the bed with a belt by his father when he was aged about 9. Sean expressed a great deal of bitterness and resentment against his father throughout the interview, but ascribed much of his father's 'faults' to the evils of intermarriage. He considered himself to be in pain all the time, not physically, but mentally, and made the distinctions clearly. He felt it was much worse to be in mental pain, and that life had treated him very unfairly.

Despite Sean's difficulties, he gave a very lively animated interview peppered with jokes, some of which I privately found offensive due to their sexist/racist flavour. He enjoyed using the imagery very much and gave very detailed imaginative responses, incorporating comparisons with popular films and TV programmes.



**RESPONDENT M2 Gary**

Interview time: 2 hours (not all recorded)

Aged 23, Gary described his ethnic background as 'white Jewish'. He lives in his parents home and works as a freelance copywriter. He arranged to carry out the interview at the research unit, and had obviously given the topic of pain much forethought, as he arrived with some sketches of advertisements for pain-killing drugs that he had designed and on which he wanted some feedback. It was hard to distinguish where the 'proper' interview began, as the discussion naturally overlapped. Gary described a childhood which he felt was indulgent due to being an only child, but which had been full of minor health problems - mainly allergies which gave rise to symptoms. His most painful experience, he recalled was what he termed 'cluster' headaches, which were migraine-related. The worst one he ever had left him in acute pain for several hours until the analgesia worked. He felt that emotional states were important because they influenced immunity and control over illness. He thought that there was definitely a state that could be called 'emotional pain', and that his mother was in it most of the time, but would not elaborate why. He said he had never experienced such a state personally.

Discussion of the imagery sequence was quite tense. Although Gary was very attuned to what was entailed, he was very insistent that there must be an agenda and a 'right' set of interpretations. By this stage, I was also feeling quite anxious over the amount of control I felt I had over the interview. This was exacerbated by trying not to react to the fact that, increasingly, I was finding Gary's manner off-putting, patronising and towards the end of the interview, offensive. This was mainly due to the fact he continually made jokes of a sexual nature, and wanted to prolong the interview beyond what I felt to be its 'natural' course.

**RESPONDENT M3 James**

Interview time: 1 hour

Aged 38, James described himself as white British and his occupation as an artist, although this did not supply an income and he worked part-time as an interior decorator. His wife was a doctor. They owned their own house, and had agreed to experiment with role reversal when bringing up their two sons, now in their teens. (One of the sons, later admitting to curiosity as to what was happening, entered the dining room in the middle of the interview and proceeded to stub his toe, causing much merriment over this practical demonstration of pain!) James did not feel that he was much qualified to talk about pain, and had not had much experience of it - the worst thing that had happened to him personally was an infected varicose vein, which he did not feel counted for very much along a possible range. The most painful thing he had witnessed was his wife's labours, but felt that because there was a positive outcome, again this was not necessarily negative. He felt that the emotional response had as much validity as the physical, and that it might be more difficult to recover from wounds of the psyche. He thought the use of imagery was a valuable way to tap insights into pain beliefs, but could not stop himself responding 'technically' to the imagery, rather than emotionally.

**RESPONDENT M4 Tim**

Interview time: 1 hour 45 minutes

Aged 25, Tim thought he was English, but was unable to say for sure, as he had never known his parents, spending a large part of his childhood in children's homes. He wanted to be a theatre designer, and, despite leaving school at 16, had obtained an honours degree in the subject. He was currently unemployed, but finding occasional acting parts. Having very recently married, he lived in a squat with his wife and an artist friend; the interview

took place squeezed amongst many canvases. Tim had a variety of health problems over the last year, including a hernia, frequent bouts of influenza, and a varicose vein on a testicle needing removal. He quoted the worst pain experience as a toothache which persisted over a whole weekend, and which he was unable to get treated. He felt that, as the pain was so much nearer his head than the other problems, it made him feel far more out of control, and he ended up punching his fist into a picture and cutting his hand open. He had also mentioned in the questionnaire that he had been suffering from what he described 'panic attacks'. By the time of the interview, these had become much worse, and had an extremely limiting effect on his life in all areas. He describes the feeling

'like a physical pain, it's like a vice in my temples and an incredible pressure in my head... it's a brooding feeling within the skull.'

and had sought medical help, hoping there would be a physical cause. This would be more respectable, although he recognized he might have to accept its psychological nature. He was very unhappy about the treatment provided, resorting to tranquillisers when the symptoms were very acute, and receiving therapy, which he did not feel helped him with the here-and-now. He expressed very forcefully that these experiences were worse than any physical pain he could imagine. He saw them as a form of torture. Tim said he found the interview helpful, and he had found some relief in being able to express his feelings. He enjoyed the imagery sequence especially, as he could use his artistic knowledge, which helped his self-esteem.

**RESPONDENT M5 Walter**

Interview time: 45 minutes

Walter is a retired dentist, aged 65, of German Jewish background. He has lived in London since the beginning of the Second World War, the experience of which he did not want to recount. He lives with his wife and son in their own home, describes himself as 'very comfortably off' and came to the research unit for the interview, which was the most formal of all. Walter emphasised that his interest in pain was from a purely professional point of view, and gave very short responses, being very reluctant to elaborate. The most painful experience for him was an injection for tennis elbow, leaving him in 'horrific' pain for three hours. Although he acknowledged there was such a thing as 'emotional pain' which he could see being caused by 'a broken heart..desertion...' real pain was definitely physical, and he did not think emotion played any part. On the whole, he seemed to find the interview something of an ordeal, and though he said he liked looking at the images, because he had some knowledge and appreciation of art, he did not really see the point of the exercise.

**RESPONDENT M6 Richard**

Interview time: 45 minutes

Aged 50, Richard describes himself as English, single, living in a private furnished flat and working in a local authority housing office. He has suffered from ankylosing spondylitis for the last fifteen years, which he feels places some restrictions upon his life, but overall sees himself as having a reasonable life and able to make the most of things. Richard does not feel his condition causes undue pain, and the worst experience he had encountered was a severe toothache caused by a filling pressing on a nerve. This had lasted over a weekend until he sought emergency help, and he felt that the lack of

control was the worst aspect. He felt that emotional pain was possible and could possibly be worse than something physical, as in the case of schizophrenia or mental illness, but he would not call it real pain. For him, real pain was something that had a demonstrable physical cause which could be treated or overcome in some way.

The interview took place in his flat and felt slightly formal and reserved. He claimed to find the interview and the imagery sequence interesting, but felt unsure about what I was looking for. Richard seemed more relaxed and prepared to talk personally when looking at the pictures.

#### **RESPONDENT M7 Michael**

Interview time: 2 hours 30 minutes (not tape-recorded)

Details filled out by Michael on the questionnaire revealed that he is 35, lives on his own in a council flat, describes himself as English and is not currently employed. He lives on invalidity benefit, but occasionally works as a kitchen porter, and has been receiving treatment for the last fifteen years for paranoid schizophrenia. This is the diagnosis he has been given, but he adds:

‘I think mental illness/insanity is just behaviour which is not easily understood, but I have to live with this label’.

After receiving my letter, asking to arrange an interview, Michael arrived at the research unit and asked to see me. He was very agitated and said that although he wanted very much to take part in the research, he was worried that it was some sort of ‘trap’, which would result in his brain being operated upon, perhaps forcibly. I managed to reassure him that this was not the case, and suggested that he came into my office and had a cup of tea so I could explain what I was doing. While I was making the tea (I had several types and he had asked for one named ‘Female Harmony’), I was feeling uneasy, myself, and was quickly trying to explain the situation as discretely as possible to a colleague

when Michael reappeared in a state of great agitation, and began to shout at me, asking if I was arranging to have him 'sectioned'. I managed to provide enough reassurance to calm him, and he sat and talked to me for the next two hours, although he was still anxious, chain-smoking continuously and refusing to consider being tape-recorded. Nevertheless, he became increasingly sympathetic to the aims of the research, feeling that it had particular relevance for him as his condition led him into unbearably painful situations which could not be simplistically understood in terms of physical sensations. The worst time he could remember was when he was given E.C.T. without an anaesthetic under forcible restraint. He became very excited about the exercise with the imagery, and spent much time and effort talking about how the pictures made him feel.

## **RESPONDENT M8 Daniel**

Interview Time: 1 hour

Aged 36, Daniel's mother was Irish and his father was from Grenada, West Indies, where he had spent some of his childhood. He sees his main occupation a session musician, but also works as a drugs researcher for a medical research unit to supplement his income. He is divorced, living in a flat belonging to a housing co-operative, where his two teenage children often come to stay. His most painful experience lasted several days when a blister on his hand became infected whilst staying in the Pyrenne mountains, and he was unable to obtain treatment until he travelled to Paris, where it was operated upon. Daniel found the physical pain severe, but the worst aspect of the experience for him was the fear that he would lose the dexterity in his hand, with all the implications this held for him as a musician. He also had a period of chronic back pain, lasting about a year, which drove him to seek help outside of mainstream or allopathic medicine, and to try homeopathy and what he describes as 'spiritual healing in a black gospel' setting. The

pain did eventually go away, and Daniel does not ascribe that to any one treatment, feeling that he retains a healthy scepticism, and that his recovery could be due to all, or even none, of the remedies. He sees pain as being an extremely complex phenomenon, encompassing the physical, the spiritual and the emotional, which may not necessarily always be negative manifestations. He also felt strongly that how pain is perceived is dominated by 'Western' thought, whereas other philosophies offer a more holistic perspective. Daniel developed these themes in a profound and articulate manner using the imagery.

#### **RESPONDENT M9 Bob**

Interview Time: 55 minutes

Bob is 40, 'White British' and lives with his partner, Freda, in a council flat on a dilapidated estate. They are both registered heroin addicts, living on invalidity benefit, and Bob says he has been unable to hold down a job for 20 years, although he is currently working in a voluntary capacity for the local hospital and deriving some satisfaction from that. The interview was conducted with Freda being present, and often contributing - Bob maintained that he was not prepared to ask her to leave the room as they had no secrets from each other and always did everything together. This included withdrawing from heroin, which they went through 2 years ago, after Bob had a kidney transplant, the most painful experience of his life. He feels he was forced into the withdrawal by the offer of the transplant - when his kidneys began to fail, he was put on dialysis but was unable to inject as each time he did so, he developed peritonitis. Despite the pain of the operation, overall he feels he is probably lucky to be alive, and can cope as long as he has his methadone prescription. He feels he has experienced what he calls 'mental pain', especially the times of his life he has been in prison, but does not consider

that to be 'real' pain. He took part in the imagery exercise quite willingly but did not think many of the pictures were about pain at all.

**RESPONDENT M10      Peter**

Interview: 2 hours (not all tape-recorded)

Peter, aged 53, was an ex-journalist who had left his native South Africa in the late 1960s as a 'white' protest against the apartheid regime. He had been used to an affluent, privileged lifestyle which became progressively downwardly mobile in exile, exacerbated by bouts of depression, and leading to a difficult divorce and the loss of his job. Five years ago, he developed the first of three cancer 'attacks', which erupted in his left arm, buttock and leg. This resulted in a number of operations, including the amputation of his left leg 2 years ago. He has attended a Pain Clinic, but did not find it helpful, and has regular analgesia to manage the pain which he feels is the result of severed nerves, but which can dissipate if he becomes distracted and especially if intellectually stimulated. (He claimed to enjoy the interview so much that he forgot to take his prescription, and did not notice the pain until the interview finished.) He lives on his own in a basement flat owned by a housing co-operative, and the living room is stacked full with newspapers and books, which he regularly dips into for reference as he talks. Apart from receiving Invalidity benefit and Meals-on-Wheels, he resists adopting 'sick-role' behaviour and has a constant stream of visitors and friends, who, he maintains, use his flat as a meeting-place to discuss politics, literature, the arts or indeed any desired topic. At various points in the interview, he requested that the tape-recorder be turned off, so that he could 'chat', which included asking me about my own life, to which I acquiesced. Despite all he had suffered, he was intensely optimistic, also witty and amusing, and at times I felt unsure who was interviewing whom. Peter felt very strongly that the emotional distress



he had experienced in his life, especially his depression which he termed 'the black dog', and was he felt responsible for his wife's leaving him, was much more painful than anything he had coped with physically and that

'... physical pain can be a means of solving your emotional problems - it drowns out depression or whatever because it's so immediate and intense.'

Although he did not want to convey the impression that he had wanted to become ill in any way, he emphasised that for him his pain had a spiritual component, not in a religious sense but it had taught him the beauty of life. Peter believes that the quality of his life is perhaps higher than it has ever been. He derived tremendous pleasure from the imagery sequence, and expressed the view that this kind of research should take place in Pain Clinics as not only would it inform the researcher but it would be of great therapeutic value to the researched.

#### **RESPONDENT M11      Patrick**

##### **Interview incomplete**

Patrick was 27, married with two children under 5, living in short-life housing and earning a living as a scrapyard dealer. He had moved from Eire to London five years previously and had been informed two years ago that he was HIV positive. When I met him in the G.P. surgery he willingly completed the questionnaire, and agreed to take part in the interview. He talked in a calm manner about hearing the terrible news, which he felt to be the most painful moment of his life, causing him much despair and self-blame. He used to inject heroin and felt that sharing needles was the source of transmission. Some six months later, when I arrived at his home at the appointed time, Patrick's wife led me to his bedroom where he was very ill with pneumonia. Patrick had developed full-blown AIDS, I felt the purpose of my presence to be intrusive and left after expressions of sympathy.

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## IMAGERY

## PAIR 1

- A. The Sick Child.  
Edvard Munch 1907.  
National Gallery, London.
- B. The Hopeless Dawn.  
Frank Bramley 1888.  
Tate Gallery, London.

## PAIR 2

- A. Jamshedpur India  
Werner Bischof 1951.  
Magnum Photofile.
- B. Old Man Grieving  
Vincent Van Gogh 1882.  
Van Gogh Museum, Amsterdam.

## PAIR 3

- A. The Lady of Shalott  
John William Waterhouse 1888.  
Tate Gallery, London.
- B. Melancolie  
Edvard Munch 1918.  
Munch-Museet Oslo.

## PAIR 4

- A. Saint Sebastian.  
Gerit von Honthoust 1590.  
National Gallery, London.
- B. The Broken Column  
Frida Kahlo 1944  
Collection of Dolores Olmeda, Mexico City.

## PAIR 5

- A. Scene from a London Playground.  
Network Photographers 1989.  
Aladdin Books.
- B. Hungary 1947  
Werner Bischof  
Magnum Photofile.

## PAIR 6

- A. Two Followers of Cadamus Devoured by a Dragon.  
Cornelius van Haarlem. 1624.  
National Gallery, London.
- B. Judith Decapitating Holofernes.  
Artemisia Gentileschi c.1618  
Uffizi Gallery, Florence.

